STATE TITLE V BLOCK GRANT NARRATIVE
STATE: KS
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

To obtain a copy of the signed Assurances and Certifications, contact:

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Bureau for Children, Youth & Families
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D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

In order to solicit public review and comment as in [Section 505(a)(5)(F)], a notice requesting public input was posted on the Kansas Rural Health Information System. (KRHIS is the new electronic public health information system with postings to all local health departments, hospitals, primary care clinics and other health care providers.)

A second notice was posted February 3, 2005 in the official newspaper of the state of Kansas, the Kansas Register. The public hearing was held before the House Appropriations Committee of the Kansas Legislature on Monday, February 21 in the State Capitol. The hearing included a presentation consisting of an overview of the federal requirements for the MCH Services Block Grant Program, the services provided in Kansas, and the use of the funds.

No comments were received through these processes.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

This section puts into context the Title V program within the State's health care delivery environment. The section briefly outlines Kansas' geography, demography, population changes, and economic considerations. The overview provides an understanding of the State's current priorities and initiatives, the process for determining priorities, and factors impacting health services delivery.

Located in the central plains region of the United States, Kansas encompasses 81,815 square miles (about 2% of the land area of the U.S.). It is bordered on the north by Nebraska, on the south by Oklahoma, on the east and west by Missouri and Colorado respectively. Hills, ridges and wooded river valleys in eastern and central Kansas give way to the flat, dry, treeless High Plains of the western part of the state.

With a 2000 Census total population of 2,688,418, Kansas ranks 32nd among the states, about 1% of the U.S. population. This represents an 8.5 percent increase over the 1990 Census. Geography, climate and economic resources combine to influence the population distribution of the state. The four most populous counties, Johnson, Sedgwick, Shawnee and Wyandotte, are located in the eastern and central parts of the state. The least populous counties are located in the western part of the state. In 2003 the population density of Kansas was 33.3 persons per square mile compared with 82.2 persons per square mile for the U.S. The county population density ranged from 1,040 persons per square mile in Wyandotte county in eastern Kansas, Kansas City area, to less than six persons per square mile in one far western county. Two counties in western Kansas had population density of 1.8 persons per square mile.

Historically, Kansas has been predominantly rural. However, that trend is changing along with a similar trend for the U.S. The total population of all cities in Kansas is 2,211,271 or 81.2 percent of the total population (2003). Of the 20 largest cities in Kansas, five have populations that exceed 100,000 including Wichita (354,617), Overland Park (160,368), Kansas City (145,757), Topeka (122,008), and Olathe (105,274). These cities are all located in the eastern half of the state. The western half of Kansas has five of the 20 largest cities in Kansas, including Salina (45,833), Garden City (27,216), Dodge City (25,568), Liberal (20,067), and Hays (19,915).

In 2000 the population of the state was 86.1 percent white, 5.7 percent African American, 1.7 percent Asian, 0.9 percent American Indian or Alaska Native, some other race or mixed heritage 5.5%. Native Hawaiians and other Pacific Islanders numbered 1,313. Seven percent (7%) of the population reported Hispanic ethnicity. Immigrants or foreign-born residents accounted for only 2.5 percent of Kansas' total population.

Kansas has slightly fewer than 40,000 live births each year (39,353 in 2003). In 2003, the Kansas birth rate of 14.4 was 2.9 percent higher than the national rate of 14.0. Seward, Geary and Finney counties had the highest five-year county birth rates of 23.7, 22.3, and 21.2 births per 1,000 population respectively. In 2003, 27.1 percent of the population (736,901) were children age 18 or younger. Women of reproductive age 15-44 accounted for 20.9 percent of the population (568,347).

During the period 2000 through 2003, 54% of births occurred in 5 urban counties with 77% (180) of Kansas obstetricians practicing in 5 counties. The remaining 100 Kansas counties account for 46% of all births where 23% (54) of the state's 234 obstetricians are in practice. Forty-two (42) counties have no maternity services (ten counties have no hospitals). Thirty-seven (37) rural and frontier counties average fewer than 40 births per year.

Over the past decade, Kansas has seen an increase in the diversity of its population. From 1990 to 2000, the Hispanic population increased by 101% to 188,252. The Asian and Pacific Islander population increased by 51.6 percent to 48,119. The American Indian and Alaska Native population increased by 13.5 percent to 24,936. The African American population increased by 7.8 percent to 154,198. The increase for the white population over the same period was only 3.7 percent (2,231,986

to 2,313,944).

Approximately 8.7 percent of the Kansas population five years of age and older speak a language other than English at home according to the 2000 Census. Of these 3.9 percent speak English less than 'very well.' Between 1990 and 2000 there was a 66% increase in the population speaking a language other than English in the home. The Kansas percent increase was greater than the average increase for the Midwest (66% versus 43%) but considerably less than the increase for the South (62%).

Compared to the U.S. population (2003), a lower percentage of Kansans live in households with incomes below the federal poverty level (10.8% versus 12.5% for the U.S.) and a lower percentage of children under age 18 live in households with incomes below the federal poverty level (14.5% versus 17.6% for the U.S.). Twenty percent (20.1%) of Kansas' children living in poverty are of Hispanic ethnicity. Overall, the percent of Kansas' families living at or below the federal poverty level is 6.7%. Poverty is more common in Kansas' families headed by single females and those with children under the age of five in the household, regardless of race or ethnicity. Most Kansas children under age 18 living in poverty live in three population centers: Sedgwick Co. (Wichita), Wyandotte Co. (Kansas City, KS) and Shawnee Co. (Topeka).

Educational attainment for Kansans is favorable compared to the U.S. About 86.0% of Kansans age 25 and older are high school graduates compared to about 80.4% for the U.S. The percent of those age 25 and older with college degrees is slightly higher for Kansas than for the U.S. (25.8% versus 24.4%).

The recovery of the Kansas economy has been more modest than that of the national economy following the 2001 national economic downturn. Even though the state experienced overall employment growth in 2004, the economy is expected to continue modest growth below that of the U.S. in 2005. The monthly average unemployment rate for 2004 was 5.5%. The projection for 2005 is that the unemployment rate will remain uncharacteristically above the national rate of 5.8%.

In Kansas, total state health expenditures per capita for state fiscal year 2001 was slightly lower ($3,275) than for the U.S. ($3,590). The total includes both state-funded operating and capital spending. For state fiscal year 1999, Kansas state health care expenditures per capita was lower ($698) than for the U.S. ($872).

In 2005, there were eleven federally qualified health centers with sites in Kansas and 173 federally certified rural health clinics. There are 117 community hospitals of which 76 are Critical Access Hospitals. With 175 physicians per 100,000 population, Kansas was lower than the national ratio of 198 physicians per 100,000. Kansas ranked 31st among states in physicians per capita. There were 5,407 active patient care physicians in Kansas in 2003. Twenty-five percent of active patient care physicians are female (1,354).

The rate of registered nurses per 10,000 population in Kansas was slightly higher than the U.S. This was equal to 883.1 RNs per 100,000 population in Kansas in 2000 compared to 780.2 for the U.S. Registered nurses include advance practice nurses such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. There were 1,685 dentists, 2,020 dental hygienists, and 2,840 dental assistants practicing in Kansas in 2000. There were 62.6 dentists per 100,000 population in Kansas in 2000, slightly below the national rate of 63.6. The per capita ratios of dental hygienists and dental assistants were higher than their respective national rates. The number of dentists in Kansas increased 38% between 1991 and 2000 while the state's population grew 8%. The result was a 28% increase in dentists per capita compared to a 16% increase nationwide.

Overall, there were more than 126,000 people employed in the health sector in Kansas in 2000, 9.6% of Kansas' total workforce, higher than the national rate of 8.8%. Kansas ranked 13th among states in per capita health services employment. In 2000, Kansas ranked 8th among states in the number of

hospital beds per 100,000 population.

According to the U.S. Census Bureau's Current Population Survey, in 2003, 11.0% of all Kansans have no insurance coverage. This compares favorably with data for the U.S. population at 15.6% uninsured. Eighty-nine percent (89.0%) of Kansans were covered by private or government health insurance, compared to 84.4% for the U.S.

State Issues Impacting Women and Children

According to the 2001 Kansas Health Insurance Study, approximately 8% of Kansas' children age 18 and under have no health insurance. Over two thirds of Kansas children are covered by private insurance and fifteen percent are covered by public insurance. Insurance status is not so favorable for women of reproductive age (15-44) with 13.2% uninsured. Of those with coverage, 82.6% are covered by private insurance and only 4.3% by public insurance.

The same study put the average annual growth of Medicaid enrolled at 5.6% in Kansas compared to 9.8% for the U.S. Fifty-two percent (52%) of Kansas Medicaid enrollees are age 18 or younger. Kansas maintains the eligibility level for the Medicaid program at the federally required minimum. See Form 18 for eligibility levels for Medicaid and State Children's Health Insurance Program (SCHIP), called HealthWave program in Kansas.

Among Kansas Medicaid enrollees, 55.3% are enrolled in managed care compared to 58.3% for the U.S. The percentage of Medicaid spending on children under age 18 (15%) in Kansas is the same as for the U.S. However, long-term care (fee-for-service) Medicaid spending is higher (53%) compared to the U.S. (38%). The number of births financed by Medicaid in Kansas rose from 7,718 (23% of Kansas live births) in 1999 to over one third in 2002. Joint application was allowed for children's Medicaid and SCHIP-funded separate programs in 2002. Kansas is one of 18 states in the U.S. with 12-month continuous eligibility for Medicaid eligible children. Due to budget shortfalls, Kansas has followed the lead of other states in implementing cost-sharing requirements for the Kansas SCHIP program but not decreasing benefit levels. Kansas has not applied for a waiver to expand eligibility for Medicaid services to women from the existing 60 days postpartum to 2-5 years as has been done in several other states.

Kansas has no laws requiring coverage of all FDA-approved prescription contraceptives by all health insurance policies written in the State that provide prescription coverage. There is no mandated coverage for infertility diagnosis and treatment. However, there is mandated direct access to OB/GYN limited to one visit per year from an in-network OB/GYN. OB/GYNs are not mandated as primary care providers. Kansas law mandates benefits for breast and cervical cancer screening. Kansas laws also require insurers to provide coverage for diabetic supplies, equipment, and/or out-patient management training. Insurance coverage of newborn hearing screening is not mandated.

Even though insurance coverage and financing mechanisms dominate policy discussions about the health of Kansans, there is a strong role for public health in prevention and early intervention, health promotion, and basic gap filling services. The state health agency operates within a framework of legislative authority. In partnership with 99 local health departments operating in 105 counties, the state health agency carries out its public health mandate.

In 2004-2005, MCH completed a five year needs assessment for the maternal and child health population selecting nine priorities for the state for 2006-2010. The project called MCH 2010 included 70 expert panelists broadly representative of the geographic and racial/ethnic diversity of the state. Panelists included teens, family members, providers, advocates, state agencies, and others. Currently, workplans are being developed to address each of the nine state priorities. Indicators have been selected to measure state progress in addressing each need over the five year period. These will be reported by level of the Title V pyramid - direct services, enabling services, population-based services, and infrastructure-building services. All this will and will be included in the 07 MCH application and annual report.

Kansas MCH/CSHCN participates in the Heartland Genetics Consortium. As part of this collaboration, Kansas and the two Dakotas will receive technical assistance in October of 2005 on development of a state genetics plan.

State Priorities and Initiatives/Title V Role

The two most important policy agendas for the state this year were education and health care. Not unexpectedly, these two account for a large part of the growth of state expenditures while various sources of state revenues have declined or remained level. The Governor's proposed education plan which depended on a tax increase was set aside in the 2005 legislative session in favor of a more modest one-year spending increase for education with no tax increase. By passing this modest increase, the legislature hoped to assuage the courts given the Fall, 2004 court ruling on the inadequacy of education financing in the state. The court challenge is expected to continue and possibly to impact funding for other state agencies.

Meanwhile, the State Early Childhood Comprehensive Systems (SECCS) grant stakeholders incorporated into their state plan the components from the Governor's school financing plan relating to young children including all day kindergarten, increased support for 4 year old at-risk programs, and funding for evaluation of Parents as Teachers. In turn, the Governor endorsed the SECCS plan and staffers are participating in the implementation process.

The second most important policy agenda was expanding eligibility while at the same time holding down health insurance costs. The Governor's Office proposed creation of a health authority within the Office of Administration that would combine Medicaid, SCHIP, and the State Employees Health Insurance programs to obtain greater purchasing power, and lower prescription drug and administrative costs. During the 2005 legislative session, the proposal was reworked by the majority party and passed. The legislators maintained the key points of combining programs/purchasing power. The plan diverged by establishing a separate State agency more answerable to the legislature while at the same time appropriating no funding for a separate state agency.

The timeline for the current plan (House Substitute for Senate Bill 272) is as follows: July 1, 2005 Kansas Health Policy Authority established; July 1, 2005 transfer programs from Kansas Department of Social and Rehabilitation Services (SRS) to Dept of Administration, Division of Health Policy and Finance; January 1, 2006 Assumption of Responsibilities by Authority; March 1, 2006 Authority Plan Submitted to Legislature; July 1, 2006 Transfer programs to the Authority; Beginning of 2007 Legislative Session - Plan submitted for transfer of additional Medicaid funded programs to the Authority (could include mental health services, Home and Community-Based Services waivers, nursing facilities, substance abuse prevention and treatment and the state hospitals); Beginning of 2008 Legislative Session - Plan submitted to legislature for assuming responsibility for purchasing health care services for Dept. on Aging, Dept. of Corrections, Juvenile Justice Authority, Dept of Education - Local Education Agencies (LEAS).

At least one area of KDHE will be impacted by this major reorganization, the Center for Health and Vital Statistics (CHES). The administration of the Health Care Data Governing Board and staff to that board currently reside in the CHES Office of Health Care Information. Administration and staffing are expected to transfer to the new state agency in January of 2006. The impact of this transfer on access to hospital discharge and other data by state health department programs cannot be determined at this time.

Federal legislation requires coordination between Title V and Title XIX of Social Security Act (MCH and Medicaid). The SRS/KDHE Interagency Agreement spells out the relationship between the state Medicaid agency and the state MCH agency in Kansas. It is certain that the interagency agreement will need to be reviewed in light of these recent changes in Kansas. Meanwhile, MCH/CSHCN acts in an advisory capacity to the state Medicaid agency relating to services for pregnant women and children. Another advisory role is to the state insurance agency and to the legislature in insurance

matters relating to pregnant women and children.

Although it was not funded, the health promotion portion of the Governor's health plan, based on a similar plan in the state of Arkansas, has been implemented through the Office of Health Promotion in KDHE. The focus is on nutrition and physical activity in the work place and in the community with school-age, adult and elderly populations. School age efforts are coordinated with the Department of Education through CDC's Coordinated School Health grant to Kansas. Maternal and Child Health staff participate in the state advisory group for the Coordinated School Health project and provide an important link to school nursing services in the state. The Coordinated School Health program links with health education and physical education teachers and the school nutrition services mandated by the Child Nutrition Act.

In the Spring of 2005, Healthy Kansans 2010 was launched by the Office of Health Promotion within KDHE. Powerpoint data presentations with recommendations were provided by individuals from within and outside KDHE relating to Healthy People 2010 priorities. At the final meeting of the consensus group on May 12 the participants were asked to vote on the key priorities for KDHE for the next 5 years, keeping in mind the presentations and the 10 leading health indicators. Following are the three priority areas selected by participants: 1) Health & Disease Disparities; 2) Early identification and interventions (women and children); 3) Systems interventions to deal with Social Determinants of Health. Workgroups will be formed around each of the three priority areas and each will recommend strategies in the following areas: improved communications regarding health and public health; ongoing workforce development; surveillance and data needs; coordination and collaboration of programs. MCH/CSHCN continues to participate in this effort to establish a linkage with other planning efforts such as MCH 2010 and SECCS.

A new director of health, Dr. Howard Rodenberg, was hired this year after a two year search. House Bill 2264 passed during the 2005 session guarantees a four year term to new hires for this position. This will likely bring some stability to this key position in the KDHE. The 2004 Legislature mandated that KDHE establish an Office of Oral Health headed by a dentist but recruitment of a qualified candidate in 2005 has so far been unsuccessful. The KDHE hosted its first annual Minority Health Conference. At this event the Governor announced that an Office of Minority Health will be established in KDHE.

B. AGENCY CAPACITY

This section addresses the capacity of the Kansas Title V Agency to promote and protect the health of all mothers and children, including CSHCN. It describes Kansas' capacity to provide essential public health services for pregnant women and infants, children and adolescents, and children with special health care needs.

Although the Kansas program has not completed a Capacity Assessment for State Title V (CAST-V) Programs, it has addressed core components. The program has established a vision, mission and goals for the maternal and child health population through the needs assessment process (www.kdhe.state.ks.us). Kansas included capacity assessment as part of the Five-Year MCH State Needs Assessment called MCH 2010. Through the Title V needs assessment process, Kansas has identified the priority health issues and desired population health outcomes. A review of the political, economic, and organizational environments for addressing the priority health issues was included in the needs assessment process. All relevant information was utilized to set strategic directions for the Title V program in terms of identification and implementation of organizational strategies to achieve the desired outcomes for the maternal and child health population.

Also, Kansas uses the ten essential public health services, the basis for the CAST-V assessment, to guide decision-making in all aspects of program operation. Following is an overview of Kansas' Title V capacity in relation to each of the ten essential maternal and child health services.

Essential Service #1. Assess and monitor maternal and child health status to identify and address problems. Kansas uses public health data sets to prepare basic descriptive analyses related to priority health issues. Data from the Behavior Risk Factor Surveillance System (BRFSS) that is conducted within the Office of Health Promotion is readily available and MCH has an opportunity each year to support additional modules relevant to emergent issues within MCH/CSHCN. Oral health and women's health modules have been supported in recent years. The Youth Risk Behavior Survey (YRBS) is conducted each year by the state department of education in partnership with local school districts. Previously, the data were not considered representative of the youth population due to non-participation of some school districts. This year, through the auspices of the CDC Coordinated School Health Program, the data will be representative and useful to the Title V program in tracking youth health behaviors.

Vital statistics data are of high quality and readily available to the Title V program for assessment purposes. As of January 1, 2005, a new electronic system is in place that implements the new national standards for vital records. Other new data elements will improve the ability of the MCH/CSHCN programs to assess birth/death and birth risk data. Other data sets maintained by other bureaus within the department that the Title V program uses for various analyses include immunization, cancer registry, child care licensing, STDs, HIV, state laboratory, primary care, farmworker health, trauma registry, as well as BCYF program services data systems (WIC, MCH, CSHCN, Part C, Family Planning, Newborn Screening, Newborn Hearing Screening).

Title V has access to data sets outside the BCYF and the Department. Some examples of the type of data that are routinely accessed are Medicaid data (MMIS & Clearinghouse), hospital discharge data, department of transportation data (motor vehicle accidents), Kansas Bureau of Investigation (intentional injuries), department of social services, education department (school lunch program, school injuries). The annual MCH Block Grant submission includes a good representative sample of the types of data accessible to Title V. The State Systems Development Initiative (SSDI) grant provides a good overview of data quality and data linkage capacity.

MCH has shifted resources to two epidemiology positions for which orientation and training have been completed. The epidemiologists serve as data analysts and resource persons for MCH2010, the Kansas MCH 5-year state needs assessment, for the KDHE Healthy Kansans 2010, for the analysis of CSHCN National Survey and birth defects data, and numerous other projects throughout the year. There is not sufficient capacity to conduct analyses of MCH data sets that go beyond descriptive statistics, although there has been some work in this area. The open mouth survey of Kansas third graders and the analysis of poison control center data are good examples of the latter. Increasingly, BCYF epidemiologists and other staff have compared health status measures across populations. The Title V Information System (TVIS) on the Maternal and Child Health Bureau (MCHB) website is used often as a means of comparing health status measures for Kansas with those of other states. The state has very limited capacity to generate and analyze primary data to address state- and local-specific knowledge base gaps although there will need to be some work in this area particularly as this relates to CSHCN priority needs (medical home, youth transition, and financial access) since these will need information beyond that available from the CSHCN National Survey.

Primary and secondary data are routinely analyzed and used in policy and program development across all BCYF programs but the quality and consistency of the analysis varies based on staffing considerations. MCH grants to local agencies require local needs assessment to set local priorities although capacity to provide training and technical assistance to the local agencies is limited. Local agency epidemiological capacity ranges from highly sophisticated, particularly in urban areas, to very unsophisticated, particularly in rural areas. Training of local staff to achieve consistency across all local agencies is needed. Training of state agency staff to achieve consistency across all BCYF programs is needed as well.

Essential Service #2. Diagnose and investigate health problems and health hazards affecting women, children, and youth. BCYF uses epidemiologic methods to respond to MCH issues and sentinel events. Recent examples of these activities are: the linkage of lead screening data with Medicaid

EPSDT data; review of low birth weight data in response to legislative concerns; gastroschisis cluster study in response to physician concerns; review of lead screening data for pregnant women in cooperation with the pediatric toxicologist at the Mid-America Poison Control Center and the perinatologist from the Kansas Perinatal Council. Through these and other efforts, the Title V program engages in collaborative investigations and monitoring of environmental hazards (e.g., state schools for the deaf and blind, juvenile correction facilities, birthing centers) to identify threats to maternal and child health. The Title V program is seeking funding to implement SB 418 of the 2004 session, providing statutory authority for a birth defects surveillance system. An analysis of the state's current activities shows many gaps in establishing a surveillance system which meets the standards set by CDC. Increasingly, the MCH epidemiologists serve as the state's expert resource for interpretation of data related to MCH issues. The Title V program is regularly consulted on MCH data issues and staff participate as experts in planning processes requiring analyses. The agency provides leadership for reviews of fetal, infant, child, and maternal deaths through its work with the KPC. The program has minimal contact with the state child death review board and information comes through Vital Statistics. Through the MCH needs assessment process, Title V uses epidemiologic methods to forecast emerging MCH/CSHCN threats that are addressed through planning processes.

Essential Service #3. Inform and educate the public and families about maternal and child health issues. Title V has no health education plan per se and there are no Title V health education staff per se. Health education functions are incorporated into the job duties of Title V clinical staff. There is no designated funding at the state level for health education activities, such as for print or media campaigns. Title V does not routinely assess priorities for health education services and appropriate audiences for those services. The exception to this is Healthy Start Home Visitor services. Home visitors provide individual-based health education for which there is a formal annual assessment. Visitors receive training in need/deficit areas. The oral health program is another exception. The oral health website has a wealth of information for parents and families, for providers and others on oral health. Health education is a significant part of the emergent Office of Oral Health. The CSHCN program incorporates transition information and education at specialty clinics. Grants to local organizations do not require particular individual-based health education activities. There is some general agreement that this area requires further review.

Even though there is no routine mechanism for identifying existing and emerging population-based health information needs, Title V has engaged in population based health information services, providing health information to broad audiences. There is no state or federal funding set aside for public awareness campaigns on specific MCH issues, so that foundation or other support is the usual source of financing for media campaigns. Title V collaborated with Kansas Action for Children on a statewide media campaign to raise public awareness about the importance of oral health for pregnant women and children. MCH partnered with the March of Dimes on a public health education campaign on the importance of folic acid usage. Nutrition and WIC services have expanded breastfeeding promotion and health education through all local health departments. Abstinence Education utilizes the services of a contractor to assist with its media campaign and health education activities. The CSHCN program is in the process of expanding the toll-free resources to the internet. Each of these activities was generated independently rather than in response to an overall review of state needs. With the addition of staff, the public information office of KDHE has new capacity to assist programs with websites, print materials, news releases, and other health education services. During the past year Title V has received assistance in framing messages relating to MCH.

Essential Service #4. Mobilize community partnerships between policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems. The Kansas Title V program is strong in this area, responding to community MCH concerns as they arise, regularly communicating with community organizations. Needs assessments and planning activities engage community audiences on state and local MCH status needs. The Title V program supports the office of health care information to produce issue- and population-specific reports that are distributed widely in the state. Informal mechanisms are utilized to obtain input into the Title V program on MCH/CSHCN needs. The 5-year state needs assessment process is a formal mechanism for obtaining community input into the program. Funding and technical assistance are provided to local

providers for services that are determined locally through a community needs assessment process. No additional funding is available for local programs to establish community advisory boards but grants to community organizations such as the comprehensive school health services and disparity initiatives require local advisory boards and specify composition. Kansas Title V supports coalition and stakeholder groups primarily through technical assistance, although as in the case of the State Early Childhood Comprehensive Systems grant, funding may also be provided for planning activities.

Essential Service #5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families. Title V assembled a Panel of Experts for the five-year state MCH needs assessment, MCH 2010, played a major role in development of the State Early Childhood strategic plan, and participated in the Healthy Kansas 2010 process to determine priorities for the state agency. MCH/CSHCN routinely lead and/or participate in data-driven decision making and planning activities. The annual and five-year Title V grant application and needs assessment cycle serves as the cycle for systematic review of progress on objectives. Title V actively promotes the use of scientific knowledge base in the development, evaluation, and allocation of resources for policies, services, and programs. A project underway for the MCH epidemiologists is production of an annual MCH state report. The national and state performance measures will serve as the basis of the data in the report. The format for the annual publication, Reportable Diseases in Kansas, will be used to generate the MCH annual report.

MCH/CSHCN use three formal advisory structures to advise Title V and KDHE: the Kansas Perinatal Council, the Kansas Child and Adolescent Health Council, and Families Together. Each of these groups holds quarterly meetings. Title V has input into the agendas to assure that key issues facing the state Title V agency are addressed. MCH epidemiologists are available to support the deliberations of the groups. Kansas Title V regularly utilizes data available within the department as well as data from other agencies and organizations (state, local and/or national) to inform state MCH health objectives and planning. These efforts are most evident in the annual MCH Block Grant submission which utilizes a systematic process to produce an overview of the health of all mothers and children in the state.

MCH/CSHCN staff are involved in multiple state-level advisory councils: Governor's Commission on Autism, Kansas Commission on Disability Concerns, Head Start, Kan-be-Healthy, Traumatic Brain Injury, Assistive Technology. Staff routinely partner with other agencies and programs as listed in the collaboration section of this application. Title V has a number of formal interagency agreements for collaborative roles such as the agreement for the Individuals with Disabilities Education Act (IDEA) programs Part C (located in the state health agency) and Part B (located in the state education agency); agreement with KU's poison control center to assist in national certification efforts; SRS/KDHE interagency agreement primarily focusing on Medicaid and SCHIP collaborative efforts, among others. This latter agreement will need to be reassessed given the reorganization of the Medicaid and SCHIP programs to a newly established state agency that is described in the state Overview section. This will likely be done after stabilization of programs has occurred. The Title V program has contributed to the planning processes of several state initiatives and implementation of a joint state initiative. Routinely, Title V staff are consulted by others needing guidance on services to MCH populations. Over time there has been a pattern of a gradual shift towards other programs developing independent capacity to address traditional MCH (BCYF) issues. Two examples of this shift come to mind: hiring of a staff person within the Bioterrorism program to address MCH issues and development of programs to address needs of school aged population by chronic disease through the CDC Coordinated School Health grant. Still, the BCYF serves as the representative of the state health agency at key meetings such as public/legislative hearings relating to MCH/CSHCN issues.

Essential Service #6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being. BCYF has the responsibility for assuring legislative and regulatory adequacy for MCH/CSHCN. Title V has not coordinated a formal review of adequacy and consistencies of legislative/regulatory mandates across all programs serving MCH populations for a number of years. There have been a number of reviews

of specific legislation or regulations due to emergent policy or program issues. Recently, Title V participated with child care licensing and the Kansas Perinatal Council in a review of outdated birthing center regulations. KPC recommended that the state adopt national standards for birthing centers. Title V staff routinely attend legislative hearings related to maternal and child health issues and provide testimony. Examples of these activities are hearings on fluoride in public drinking water and impact on the oral health of children, and the importance of community/workplace support for breastfeeding. The Title V program engages in strategies for informing elected officials about legislative/regulatory needs for maternal and child health such as when the oral health survey report was provided to legislators and others in policy making positions to fill knowledge gaps relating to the oral health of Kansas children. As part of the KDHE budgetary process, BCYF puts forward proposals for legislation, budgetary or regulatory changes each summer. Proposals are reviewed by an internal executive team and prioritized in terms of the overall needs of the agency. The budget is submitted to the Governor in early Fall.

Title V staff are encouraged to participate in professional organizations and to engage with other state agencies in the development of licensure/certification processes. Kansas Public Health Association and Kansas State Nurses Association are examples of participation. Title V provides leadership to the development of quality standards of care for women, infants and children in collaboration with other agencies and organizations such as Medicaid's EPSDT Advisory Board, Hearing Screening Guidelines and Vision Screening Guidelines. See birthing center regulations as in #5 above. Specialty clinic standards are another standard setting activity. The Title V program has collaborated with Medicaid and SCHIP to incorporate MCH standards and outcomes such as the Low Birthweight Pregnancy Improvement Project with First Guard, adoption of the CSHCN definition in managed care contracts, and use of the CSHCN program for consultation regarding care. MCH promotes Bright Futures as the standard for local MCH agencies throughout the state. MCH routinely conducts record and site reviews of local agencies and allocates staff resources to provide technical assistance so deficiencies can be addressed. The MCH aid to local program has initiated a risk-based schedule for reviews of local agencies to improve allocation of technical assistance to those agencies most in need.

Essential Service #7. Link women, children and youth to health and other community and family services and assure quality systems of care. The Kansas Title V program develops, publicizes and routinely updates its Make a Difference Information Network (MADIN) toll-free line. There are plans to use website, TV, radio, and print advertisements to publicize the line. At all points of contact with women, children, and families the Title V program provides verbal information and/or print materials about publicly funded health services (e.g., family planning, WIC sites). The Title V program assists localities in developing and disseminating information and promoting awareness about local health services through such activities as community resource and referral lists that are maintained at each local agency. There has been no systematic effort to evaluate the effectiveness and appropriateness of efforts to link women and children with services.

Kansas Title V coordinates with MCOs on outreach and home visiting services for hard to reach populations. Innovative methods of providing services such as one stop shopping in Wyandotte County and CSHCN involvement in Juniper Gardens have been encouraged although there has been no funding for these efforts. Technical assistance is provided at conferences and at on-site visits to local agencies, also to providers in identifying and serving hard-to-reach populations. BCYF disseminates information on best practices to local agencies, providers, and health plans across the state.

Tracking systems for universal, high risk, and underserved populations are developed and routinely evaluated such as the recent evaluation of newborn metabolic screening and followup system in preparation for the application to CDC for birth defects surveillance system funding. In collaboration with partners, CSHCN is implementing new outreach through vital records data. Program information and brochures will be mailed to parents of children with high risk conditions noted on the birth certificate. MCH and CSHCN provide or pay for direct services not otherwise available. Examples of these services are: child health assessments for school entry through local health departments for

uninsured and underinsured children; and CSHCN medical specialty clinic services.

Resources are provided to strengthen the cultural and linguistic competence of providers and to enhance their accessibility and effectiveness. CSHCN and other staff routinely authorize interpreters at out-patient appointments for families who have English as a second language and phone for assistance. Interpretation services are available within KDHE through the public information office and the farmworker health program. All BCYF staff have participated in cultural competency training as well as continuing education opportunities as these are available. The Title V program assures that local health departments and other local agencies interface with culturally representative community groups and prepare outreach materials and media messages targeted to specific groups. There has been no effort within the BCYF to recruit persons of color and bilingual staff.

This year, monthly meetings with Medicaid staff were suspended following the exit of one key individual. Proposals for Medicaid waivers and other collaborative activities were dropped as Medicaid staff were shifted to new responsibilities and inundated with legislative inquiries about a proposed major state reorganization. Staff meet with foundations, professional organizations and other potential partners regarding established and new ventures. Interagency agreements are routinely reviewed for effectiveness and appropriateness. Kansas works with the Medicaid agency and Insurance Commission as appropriate on enrollment screening procedures, tracking of new enrollees' utilization of services and consumer information.

MCH/CSHCN provide leadership and resources for a statewide system of case management and coordination of services by convening community providers and health plan administrators to develop model programs and linkages. The Title V program distributes best practices information throughout the state via its website, at conferences, and through program-specific training. Kansas provides leadership and oversight for systems of risk-appropriate perinatal and children's care and care for CSHCN including: cross-agency review teams; developing and monitoring risk-appropriate standards of care; and, routine evaluation of systems.

Essential Service #8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs. A link between the Title V program, the school of public health, and other professional schools to enhance state and local analytic capacity has not been established. Internship/practicum students have not been used to any great extent. Academic partnerships, joint appointments, adjunct appointments, MOUs with academia, and sabbatical placements have likewise not been considered. Title V staff occasionally guest lecture at professional schools in the state such as the school of social welfare and the public health certificate program. MCH/CSHCN collaborate with the primary care program to monitor changes in the public health workforce. Resource inventories of facilities and programs are also available through this source. Geographic coverage and availability of services and providers are continually monitored. The 5-year state needs assessment addresses workforce issues and workforce gaps are considered in overall program planning. Examples of activities to address workforce shortages include: Title V coordination with Medicaid, the Kansas School Nurse Organization, the Kansas Association of Local Health Departments, and others to assure statewide fluoride varnish training for nurses. Another example is BCYF coordination with Head Start, Early Head Start and other early childhood providers to adopt a quality curriculum for home visitors in the state and assure consistent training for home visitors across all programs.

Kansas MCH/CSHCN builds the competency of its workforce through support for continuing professional education for staff. All staff maintain an Individual Professional Development Plan (IPDP). They participate in orientation and training and in ongoing in-service education. Title V staff are encouraged to log on to mchcom.com archived materials to obtain information on emergent issues. Staff participate in Leadership Conferences, the annual AMCHP meeting, and other in-state and out-of-state education opportunities. BCYF in-service meetings are held on the first Monday of each month. Topics and speakers are drawn from suggestions of participants. All BCYF supervisors collaborate with state human resources office in establishing job competencies and qualifications. If relevant, Title V includes job qualifications in contract requirements with local agencies as, for

instance, in requiring multidisciplinary teams for prenatal care coordination services, or nursing/social work services for case managers.

Essential Service #9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services. Routine monitoring is assured for all MCH/CSHCN state-funded services. Neither MCH nor CSHCN has routinely evaluated outcomes of the services provided. All Title V issued grants require that projects will participate in routine monitoring. All require reporting submission of qualitative and quantitative data. Some but not all require submission of an evaluation plan. For others such as teen pregnancy prevention, a contract is secured with an outside evaluator as from academia. Technical assistance may be provided to local agencies to design, analyze, and interpret their data depending on the program. State data is available to local agencies to facilitate implementation of their community assessments and evaluations through Kansas Information for Communities and other data sources. This year as part of an evaluation process, the BCYF organized a review of lead screens completed during the EPSDT visit for children participating in the state Early Head Start program.

Consumer satisfaction is routinely assessed for all programs. Various mechanisms are used to assess satisfaction including mail-in postcards provided at the time of the service, phone surveys, family advocacy feedback, and focus groups. The Families Together contract includes a requirement for assessment of client satisfaction with services. BCYF performs comparative analyses of programs and services when data are available across different populations or service arrangements such as for family planning or WIC.

Generally, the results of monitoring and evaluation activities are not reported to program managers, policy makers, communities and families/consumers. The exception to this rule would be when there are deficiencies and actions will be taken. The Title V program disseminates relevant state and national data on "best practices." MCH plans quality improvement activities and communicates these to local agencies and other groups as needed. Information from evaluation and quality improvement activities does not necessarily translate into programs and practices. Interest groups outside the Title V agency are more likely to influence program and policy development. Thus, there is a need for stakeholder involvement in all phases of planning, program development, operation and evaluation.

The Title V program has not identified a core set of indicators for monitoring outcomes of private providers and is not "at the table" in discussions with insurance agencies, provider plans, and others about the use of MCH outcomes in their own assessment tools.

Essential Service #10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems. The MCH program disseminates ZIPS, a monthly newsletter which abstracts current MCH research and reports to the readership. While BCYF staff do not engage in much research, if research is undertaken it is widely disseminated upon completion. The BCYF and KDHE are highly regarded for the availability of high quality data regarding many diverse health-related issues. Only very limited staffing resources are available for research, for local demonstration projects and special studies. Much of the research work is of a collaborative nature and done in consultation with our staff rather than directed by our staff. For instance, BCYF is collaborating with the Bureau of Epidemiology and Disease Prevention in a research project to determine immunization status of pregnant women.

C. ORGANIZATIONAL STRUCTURE

The Secretary of the Kansas Department of Health and Environment (KDHE) is appointed by the Governor and serves on the Governor's Cabinet. The Secretary reports directly to the Governor. Prior to the Spring of 2005, there were four divisions under the KDHE Secretary: Health, Environment, State Laboratory, and Center for Health & Environmental Statistics. A reorganization in 2004 consolidated these to three divisions. The Center for Health and Environmental Statistics was moved

under the Division of Health and the Center Director now reports to the Director of Health. The Director of Health serves as the State Health Officer.

The Division of Health has five Bureaus: Bureau for Children, Youth and Families (maternal and child health); Bureau of Child Care Licensing and Health Facilities (child care & hospital regulation, credentialing); Bureau of Consumer Health (lead program; food service inspections); Bureau of Epidemiology and Disease Prevention (infectious disease, bioterrorism); and the Bureau for Health and Environmental Statistics. There are three Offices: Office of Local and Rural Health (manpower, primary care, migrant health, hospital bioterrorism); Office of Health Promotion (chronic disease); and Office of Oral Health. An effort is underway to establish a fourth Office of Minority Health.

The Bureau for Children, Youth and Families (BCYF) administers the MCH Services Block Grant. It has four sections: Nutrition and WIC Services; Children's Developmental Services, Children and Families Services; and Children with Special Health Care Needs. Please refer to the organization chart in the Attachment file. Also, refer to the BCYF organizational structure on the BCYF website at www.kdhe.state.ks.us/bcyf.

Within the Bureau there are a number of cross cutting initiatives such as oral health and epidemiology. In April, 2002, the BCYF hired a registered dental hygienist to build oral health capacity in the agency, to integrate oral health education and health promotion into all maternal and child health programs and to serve as an agency link with emergent oral health coalition efforts in the state. This position has since been integrated as Deputy Director into the new Office of Oral Health. Recruitment of a Director (dentist) is underway. The Deputy Director continues to provide consultation, technical assistance, assessment (oral health survey), policy development (coalition-building), and assurance (fluoride varnish training). She serves as consultant to all Bureau programs including MCH/CSHCN and WIC. The Bureau has two epidemiologists that serve as consultants to all programs. They interface with epidemiological work done in other Bureaus inside the agency and with other organizations and efforts in the state. One epidemiologist serves as the State Systems Development Initiative project coordinator. Both epidemiologists coordinate all data analyses for the MCH/CSHCN needs assessment with Envisage Consulting. Both conduct assessments and evaluations of MCH programs, conduct original MCH research, and address epidemiologic needs of the Bureau. Each of the Sections is attempting to build data capacity through staff training and education and rewrite of job descriptions to require data skills for newly hired employees.

The Children & Families Section includes the following responsibilities: 1) Systems development activities for perinatal systems of care including coordination with Perinatal Association of Kansas; 2) Systems development for child, school and adolescent health care, in partnership with the Kansas Chapter of the American Academy of Pediatrics, Kansas School Nurse Association and others; 3) Maternal and Child Health grants to assist local communities to improve health outcomes for pregnant women and infants and for children and adolescents; 4) Women's Health Care and Family Planning - Systems of care and grants to communities to support the health of women in their reproductive years; 5) Other grants targeted to specific populations and needs - teen pregnancy prevention; adolescent health disparities; abstinence education, comprehensive school health clinics.

Children with Special Health Care Needs assumes the following responsibilities: 1) Systems development activities - promotes the functional skills of young persons in Kansas who have a disability or chronic disease by providing or supporting a system of specialty care for children and families including specialized services and service coordination, quality assurance, and community field offices; 2) Make a Difference Information Network (MADIN) - Assists children and adults including those with disabilities, their families and service providers to access information and obtain appropriate resources. MADIN serves as the MCH toll-free line.

The Children's Developmental Services Section includes the following programs: 1) Infant-Toddler Services (Part C of IDEA) - Promotes the early identification of developmental delay and disorders through child find, services coordination (case management), resource referral and development, and

direct service provision for eligible infants and toddlers and their families; 2) Newborn Screening - Assures early identification and intervention for infants with PKU, galactosemia, hypothyroidism and sickle cell; 3) Newborn Hearing Screening - Assures early identification of significant hearing loss in newborn infants.

Federal law requires that Part C (KDHE) and Part B of IDEA (State Education Agency) maintain an advisory committee. The Kansas Coordinating Council on Early Childhood Developmental Services serves in this capacity and the staffers for this council have their offices in the BCYF. Members are parents of children with special needs, legislators, early intervention service providers, state agencies, and community members.

The Nutrition and WIC Services Section includes the following programs: 1) Nutrition Services - Improves the health and nutritional well being of Kansans through access to quality nutrition intervention services including educational materials, consultation services, program coordination and referrals; 2) the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - Provides nutrition education, breast-feeding promotion and support, substance abuse education, nutritious supplemental foods, and integration with and referral to other health and social services; 3) Commodity Supplemental Food Program (CSFP) - Improves the nutritional status of eligible women, infants, children, and the elderly over age 60 through supplemental foods and nutrition education.

The State health agency is responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V [Section 509(b)]. When funds are allocated to other programs outside the BCYF, the Bureau maintains legal contracts for the use of the funds, or in the case of funds allocated to other programs within the KDHE MOUs clarify the nature of the work that is done in support of the MCH priorities. All programs funded by the Federal-State Block Grant Partnership budget total (Form 2, Line 8) should be included.

Official and dated organizational charts that include all elements of the Title V Program, clearly depicted, are on file in the State Human Resources office and are available upon request at the time of the Block Grant Review.

D. OTHER MCH CAPACITY

The BCYF has 53 full-time equivalent (FTEs) positions: 5 FTEs including 2 epidemiologists are located in administration, 10 FTEs in CSHCN Section, 11.5 FTEs in Children & Families Section, 11.5 FTEs in Children's Developmental Services, and 15 FTEs in WIC. None of these positions are out-stationed in local or regional offices. The MCH Block Grant is used for 21.25 FTEs or 40% of the staffing in the Bureau. This breaks out to 2.25 FTEs in Administration, 9.0 FTEs in CSHCN, 7.5 FTEs in C&F Section, 2.0 in CDS, and 0.5 in WIC. All non-clerical staff position descriptions have been re-written to require planning, evaluation and data analysis capabilities. The qualifications, in terms of a brief biography, of senior level management employees in lead positions are as follows.

Since 2000, Linda Kenney has served as Director of the Bureau for Children, Youth and Families and Kansas Title V Director. From 1989-2000 she served as Director of the Children and Families Section in the Bureau, primarily responsible for services to pregnant women and infants, children and adolescents, and women's health. She has held positions as director of a state breast and cervical cancer screening program, director of a state mental hospital-community transition project, case management supervisor for a community disability organization, and director of a local family planning clinic. She has served on the Board of the Kansas Public Health Association (KPHA), and on a number of state and federal advisory groups relating to maternal and child health. She holds an MPH degree in Health Services Administration from the University of Pittsburgh, Pennsylvania and a bachelor's degree from Indiana University. In addition to the four Section Directors, four other staff report to her (2 epidemiologists, dental hygienist (transitioning to Office of Oral Health), 1 fiscal, 1

clerical).

Jamey Kendall is the State CSHCN Director. She has a Bachelor of Science degree in Nursing from Wichita State University. Since 1997 she has served as Director of CSHCN. Prior to 1997, she worked as a CSHCN nurse consultant (1989-1997), pediatric staff nurse at Stormont-Vail Regional Medical Center in Topeka, case manager for a Visiting Nurse Service in Fort Wayne, Indiana, and home visitor for high risk infants and families with the Wichita health department. Jamey is involved with the Kansas Commission on Disability Concerns, the Kansas Chapter of American Academy of Pediatrics Subcommittee for Children with Special Health Care Needs, Assistive Technology for Kansas Advisory Board, Kansas Asthma Coalition, Head Start Collaboration, and Governor's Commission on Autism. Nine staff report to her (2 nurse case managers, 1 social worker (toll-free line), 1 fiscal, and 5 clerical). The CSHCN program has a contract with the Developmental Disabilities Center at University of Kansas Medical Center (KUMC) and another contract with the University of Kansas School of Medicine in Wichita (UKMC-W). The staff in these two regional CSHCN offices are not included in the FTE count for the BCYF.

Ileen Meyer is a professional registered nurse experienced in serving the pediatric and young adult population throughout her 35 year career in public health. Along with her nursing background she holds a Master of Science degree in Counseling Education from Emporia State University. She has extensive experience working with adolescent health and education issues. She joined KDHE as the Director of Children & Families Section in 2000. She is involved with the Kansas Chapter of the American Academy of Pediatrics and its specialty subcommittees, Kansas Perinatal Council, Kansas Suicide Prevention Steering Committee, Early Childhood Stakeholders Advisory Committee, Head Start Collaborative Stakeholders, Kansas Safe Kids Coalition, Kansas Action for Children, Kansas Fatherhood Coalition, and Kansas Works Interagency Coordinating Council. Meyer manages a staff of 10.5 FTEs (4 nurses, 3 program planning and evaluation, 1 data entry and 2.5 clerical).

Carolyn Nelson has served as the Director of Children's Developmental Services since 2001. From 1999 to 2001, she coordinated services for the Infant-Toddler (Part C) Program at KDHE. Prior to 1999, she worked as Director of Children's Developmental Services at Arrowhead West, Inc. in Southwest Kansas and as a speech-language pathologist in Arkansas. Carolyn holds a degree in Speech-Language Communication and English from Henderson State University in Arkansas. She represents KDHE on the Kansas Division of Early Childhood Board and the Kansas Coordinating Council on Early Childhood Developmental Services. She is also involved in the Head Start Collaboration Council and Advisory Board, Early Childhood Stakeholders, the National Part C Coordinators' Association, School Readiness Task Force, Child Care and Early Education Advisory Committee, and the National Council for Exceptional Children. Nelson manages a staff of 10.5 (1 nurse for newborn screening, 1 audiologist for newborn hearing screening, 1 early childhood, 1 fiscal, 4 program planning and evaluation, 2.5 clerical).

David Thomason is the Director of Nutrition and WIC services. He has served in that capacity since 1998. From 1989 to 1998, he managed fiscal services and reimbursement in the Kansas Medicaid Program. David holds a Master's degree in Public Administration from the University of Kansas and a Bachelor of Science degree in Human Service Agency Management from Missouri Valley College. The WIC program implemented an automated WIC system for Kansas. The new WIC system will allow local agency staff to spend more time on mission oriented educational activities and less time on administrative duties. Thomason manages a staff of 14 FTEs (4 nutritionists, 2 information systems, 4 program analysts, 4 clerical).

There have been no changes to the leadership within the BCYF during the past year. BCYF staff have been appointed to a number of Governor's Initiatives: State Hunger Team, Blue Ribbon Task Force on Immunization, Bioterrorism Coordinating Council, and State Developmental Disabilities Council. Both Carolyn Nelson and David Thomason have completed the Kansas Public Health Certificate Program.

E. STATE AGENCY COORDINATION

Coordination within the State Health Agency

MCH and CSHCN work with a number of program areas on public health issues. Office of Local and Rural Health: Primary Care Cooperative Agreement; District Nursing Consultants; Community Health Assessment Coordination; Farmworker Health; Refugee Health; Trauma Registry; Bioterrorism Hospital Preparedness. Bureau of Child Care Licensing: standards for health and safety in out of home care; inspections of residential facilities; inspections for state schools for deaf and blind; inspections of birthing centers. Bureau of Consumer Health: Childhood Lead Poisoning and Prevention. Bureau of Health Promotion: Breast & Cervical Cancer Screening Program; Office of Injury/Disability Program; Youth Tobacco Prevention Program; Diabetes Control Program; Kansas LEAN Program; Arthritis Program; 5 A Day; Kansas LEAN 21. Bureau of Epidemiology and Disease Prevention: HIV/STDs Program; and Immunization Program.

Division of Health and Environmental Laboratories: Inorganic Chemistry (Lead Screening); Neonatal Metabolic Screening. Center for Health and Environmental Statistics, Vital Statistics: Perinatal Outcome Data, Adequacy of Prenatal Care Utilization Index (APNCU); hospital discharge data, and data linkages with Medicaid.

Coordination with Other State Agencies

Education and Social Services are the two State Human Services Agencies with whom MCH/CSHCN frequently has contact. MCH works with the State Department of Education on health related issues for preschool and school-age children including guidance for school nurses and administrators (see the BCYF website --- http://www.kdhe.state.ks.us/bcyf/c-f/school_resources_docs.html). There are ongoing efforts to expand the school nurse role to include preventive and primary health care at school for children and youth who are at risk including underinsured and the uninsured school population. Delegation of nursing tasks to unlicensed school personnel is an ongoing issue. Title V staff assist the State Education agency and Kansas Board of Nursing with this issue. Title V staff serves on the Statewide Education Advisory Council and attends the special education administration staff meetings. This collaboration has served to strengthen the health services components for special health care needs students in local school districts.

The federal legislation on inclusion has necessitated the reeducation of school nurses and training for allied school personnel in the provision of care to medically complex children. "Guidelines for Serving Students with Special Needs Part II: Specialized Nursing Procedures," helps local education agencies provide services to CSHCN students. This was a collaborative project between Title V and the State Department of Education. Standards for CSHCN are also underway for early childhood education programs and child care providers. Others areas of significant collaborative efforts include: Part B of IDEA, School Readiness, and School Nutrition.

Schools, health departments, and primary care providers are encouraged to use "School Nursing and Integrated Child Health Services: A Planning and Resource Guide" in tandem with Bright Futures as the standard for provision of public health services to children. Multiple professional development opportunities are provided utilizing the statewide Area Health Education Centers (AHECs) and local area education service centers as training sites. It is anticipated that a day long video conferencing format will become the norm with facilitators available at times and sites convenient for any school district.

The Social Service Agency (SRS) programs with which MCH/CSHCN has most frequent contact are Medicaid and SCHIP (HealthWave). MCH/CSHCN assists with outreach and enrollment efforts, reviews data relating to utilization patterns, assists with provider recruitment, promotes standards of care, assures provider training, among others. Local MCH agency dollars expended on Maternal and Child Health services are utilized as match for federal Medicaid dollars to provide prenatal case

management, nutrition and social work service for high risk women as well as newborn postpartum home visits. These and other collaborative arrangements are formalized in a KDHE/SRS Interagency Agreement (updated in 2002 to include HIPAA and data sharing). MCH/CSHCN staff meet monthly with Medicaid and HealthWave staff to discuss mutual concerns and to plan for identified service needs. Medicaid includes information about the WIC program in its notices to clients reminding them of immunizations due. Currently Medicaid and Family Planning are working on a waiver to extend the mother's eligibility after birth from 6 weeks to 2-5 years.

MCH/Infant-Toddler Services staff, in collaboration with Medicaid staff, have developed a Medicaid reimbursement fee for a service system of early intervention services (such as occupational therapy, physical therapy and speech-language therapy) through a specially designed Infant-Toddler early intervention Medicaid providership. Training was provided to teach the Infant-Toddler Networks how to use their providership numbers to bill for these services. In 1999, the Infant-Toddler Services Medicaid providership was enhanced to include targeted case management (service coordination) as a reimbursable service for eligible infants and toddlers. Preliminary steps were implemented to add developmental intervention services as a Medicaid reimbursable service which was added in 2002.

For the high-cost services for special needs children, the interagency agreement directs mutual referrals, cross program education, fiscal responsibilities and case management services for children participating in both Medicaid and CSHCN programs. Title V implemented linkages with the Medicaid and EDS/MMIS System so that CSHCN staff have direct access to Medicaid information on children eligible for both Title V and Title XIX/XXI.

An interagency agreement delineates mutual responsibilities between Title V and SRS focusing on referral of Supplemental Security Income (SSI) children and youth between the two agencies. A third party, the Developmental Disabilities Center assists in design of materials to improve reporting of reliable information to make an accurate determination of eligibility for SSI benefits, and recruitment and expansion of the SSI provider pool for SSI consultative examinations. Another development is training for providers who give consultative evaluations. CSHCN staff have a B agreement in place that allows increased access to SSA data.

Through the Farmworker Health with Medicaid coordination (described in the interagency agreement), children and families of migrant and seasonal farm workers receive primary, preventive, acute and chronic care services at seventy-five clinic sites. Title V staff coordinate with Farmworker Health staff in the Office of Local and Rural Health to identify methods to maximize use of individual program funds to assure access to prenatal care and specialty care/follow up for farmworkers and their families.

Title V works with Employment Preparation Services in SRS on issues such as teen pregnancy prevention and public health assistance for indigents. Title V has worked with Alcohol and Drug Abuse Services on a number of substance abuse issues including prevention programs for youth, identification and intervention for pregnant women, and treatment facility standards for pregnant substance abusers. Title V has worked with Mental Health on a state plan for adolescent health, youth suicide and other issues. MCH serves on the State Developmental Disabilities Council located in SRS. KDHE's Child Care Licensing works with Foster Care regarding quality of child placements. CSHCN works with Rehabilitation Services (Vocational Rehabilitation), Disabilities Determination and Referral Services.

Other State agencies with whom MCH/CSHCN collaborates include the following: Kansas Department of Insurance on issues of public and private insurance coverage for the maternal and child population. MCH works with the Kansas Department of Transportation (KDOT) and the Kansas Board of Emergency Medical Services through the Injury Prevention program on data and policy issues. MCH/CSHCN have participated with the Kansas Advisory Committee on Hispanic Affairs and the Kansas African American Affairs Commission on cultural and linguistic competence issues. The Kansas Advisory Committee on Hispanic Affairs provides assistance with finding translators. MCH has assisted the Kansas Department of Corrections on health standards for youth facilities, finding

providers of prenatal care for pregnant inmates.

Coordination with Other Agencies and Organizations

University and other collaborations are as follows: University of Kansas; Bureau of Child Research/Center for Independent Living; Life Span Institute; University Affiliated Programs, Kansas University Center for Developmental Disabilities, Lawrence and Parsons; Developmental Disability Center/LEND Program; School of Medicine; School of Social Welfare; Preventive Medicine; Mid-America Poison Control Center; Area Health Education Center; Wichita State University; Kansas State University; Cooperative Extension Kansas Nutrition Network; University of Kansas School of Medicine - Wichita, MPH Program; Heartland Regional Genetics Consortium (to develop State genetics plan).

MCH works with professional groups, private non-profit organizations and others such as the following: March of Dimes; American Academy of Pediatrics - Kansas Chapter; Kansas Children's Service League; Children's Coalition; Kansas Adolescent Health Alliance; Dietetic Association of Kansas; Kansas Action for Children; Families Together, Inc; Kansas Hospital Association; Assistive Technology Project of Kansas; Kansas Medical Society; Kansas Lung Association; SAFE Kids Coalition; Kansas Immunization Action Coalition; Kansas Health Foundation (KHF); Sunflower Foundation; Kansas Health Institute; Kansas Public Health Association; Perinatal Association of Kansas; SIDS Network of Kansas; Mexican American Ministries; Campaign to End Childhood Hunger; United Way; Kansas Head Start Association; Kansas Nutrition Council; Kansas Dental Association; Kansas Association of Dental Hygienists; United Methodist Health Ministries; Fetal Alcohol Syndrome pilot project; National School Readiness Indicators Workgroup; Kansas Head Start Collaboration Project.

There is an interdependent relationship between the State and local public health agencies. Kansas' 99 local health departments (LHDs) serve all 105 counties. The local health departments are organized under city and/or county government. They are mostly reliant on county mill levy funding, although some modest per capita state formula funds are provided to each county. Contracts and grants from the state health agency provide a third significant source of funding. The staffer for the Kansas Association of Local Health Departments assures coordination with KDHE. LHD representatives serve on all KDHE workgroups and committees with potential impact on LHDs.

MCH Block Grant dollars support regional public health nurse activities such as: regional public health meetings which serve as a forum for updates; technical assistance to local health departments regarding administrative issues, including billing, grant writing, budget, human resources, information systems, policy/procedures, HIPAA; technical assistance to local health departments regarding public health practice issues, including public health performance standards and competencies, as well as the MCH Pyramid of Core Public Health Services; collaboration with Heartland Center for Public Health Preparedness and University of Kansas School of Medicine, Department of Preventive Medicine and Public Health, for training sessions on cultural competency and diversity, risk communication, informatics, and public health law, through Kansas Public Health Grand Rounds series; distribution of resource publications and information necessary to support practice, including Connections Newsletter, Kansas Rural Health Information Service (KRHIS), OLRH website, Public Health Nursing and Administrative Resources Manual, and Domestic Violence Manual. Public health nurses maintain ongoing partnerships to support education/training for public health with state and regional training partners, including: Heartland Center for Public Health Preparedness, St. Louis University School of Public Health, University of Kansas School of Medicine, KU Public Management Center, Professional Associations, and Kansas Association of Local Health Departments (KALHD). Ongoing training activities include the Kansas Public Health Certificate Program, and the Kansas Public Health Leadership Institute.

Coordination with other Kansas MCHB Grants

KDHE staff are involved in numerous ways with grants that are awarded by MCHB to the State of

Kansas. The BCYF is a partner agency in the on-going collaborative efforts between the Kansas Title V agency and the Kansas City Healthy Start (KCHS) and with the Healthy Start Initiative awarded to the Wichita-Sedgwick County Health Department. The Kansas University Affiliated Program at the University of Kansas Medical Center works closely with the CSHCN program staff and contract staff actually share office space with the program. BCYF staff currently serve on the advisory board for the Traumatic Brain Injury Implementation grant and have served in the past with the Healthy Child Care Kansas grant. Staff within the bureau directly administer community project funding for the Section 510 Abstinence Education Grant, Community Integrated Service Systems (CISS) -- Early Childhood planning grant and the Universal Newborn Hearing Screening. We have written letters of support and look forward to working with the Health Systems Development in Child Care, Emergency Medical Services for Children (EMSC) Partnership and Bioterrorism grants.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Health systems capacity indicator data are shown in Forms 17-19. These data are indicative of state capacity to assess the health needs of mothers and children. Data for the years 1997-2004 are presented. This data provides critical information about state capacity to do important annual data linkages, to maintain data registries, and to routinely survey the maternal and child health populaltion.

#01: Rate of children hospitalized for asthma (ICD-9 codes: 493.0-493.9) per 10,000 children less than five years of age. Kansas MCH has access to hospital discharge data through the KDHE Office of Health Care Information. MCH epidemiologists are able to extract data and use it to track the health status of young children. The asthma hospitalization rate increased significantly from 2000 to 2001 (from 27.7 to 32.6/10,000) but it has remained relatively level from 2001 to 2004.

#02: The percent of Medicaid enrollees whose age is less than one year during the reporting year that received at least one initial periodic screen. Kansas MCH is able to access Medicaid data for assessment purposes. Although it is provisional data, in 2004, 88.4% of Medicaid enrolled infants received at least one initial periodic screen. This is considerably higher than any of the previous five years. Infant enrollment has risen (denominator), so also has participation in Medicaid services (numerator).

#03: The percentage of SCHIP enrollees whose age is less than one year who received at least one periodic screen. All data are final and there is wide variation from year to year for the years 2002, 2003, and 2004. The denominators (enrollees) are much more consistent over the last five years than are the data on infant participation (numerator). The percent of infants that received at least one screen during the year ranged from a low of 16% to a high of 80%. Neither the Medicaid program nor the MCH program has an explanation for this variation although it is possibly due to implementation of a new automation system.

#04: The percentage of women (15-44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck index. Annual Kansas data for the years 2000 through 2004 are relatively stable at 80-81 percent, thus meeting the national objective of 80%.

#05: Comparison of health systems capacity indicators for Medicaid, non-Medicaid, and all MCH populations by percent low birth weight, infant deaths per 1,000 live births, percent infants born to pregnant women receiving PNC beginning in the first trimester, and percent adequacy of prenatal care. These data are from 2000. In 2000, an outside contractor was hired by the Office of Health Care Information to complete the data linkage. Resources have not been available to repeat the data linkage.

#06: The percent of poverty level for eligibility in the State's Medicaid program for infants (0 to 1), children, and pregnant women. Kansas follows the federal minimum eligibility requirements: pregnant women and infants are eligible at 150% FPL; children ages 1 through 5 are eligible at 133% FPL; and,

children ages 6 through 18 are eligible at 100% FPL. At 60 days postpartum eligibility for women drops to about 40% FPL.

#06: The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP and pregnant women. Kansas follows the federal minimum eligibility requirements: 200% for all these groups.

#07: The percent of EPSDT eligible children ages 6-9 years that have received any dental services during the year. Kansas has seen a fairly steady increase in numbers of eligible 6-9 year olds, from 32,000 to 39,000 over the past five years. The proportion of eligible children who have received any dental services has also steadily risen from 35% to 47% over the same time period.

#08: The percentage of SSI beneficiaries less than 16 years old receiving rehabilitative services from the state CSHCN program. The percent of SSI beneficiaries receiving rehab services from CSHCN has varied slightly over the last five years, from a low of one in three in 2002 to a high of slightly less than one in every two in 2004. The numbers of SSI beneficiaries (denominator) and SSI beneficiaries getting rehabilitation services through CSHCN have remained relatively stable.

#09(A): The ability of states to assure that the MCH program and the Title V agency have access to policy and program relevant information and data. State MCH data capacity is indicated by an ability to obtain timely analyses of data for programmatic and policy issues. The MCH program is able to obtain data from the following annual data linkages: infant birth and death, birth certificates and Medicaid data; annual linkage of infant birth and WIC, annual linkage of birth certficates and newborn screening files. Hospital discharge survey data are available for at least 90% of in-State discharges. There is no birth defects surveillance system and no recent mothers surveillance system such as PRAMS.

The MCH program has direct access to data files for: infant birth certificates and infant death certificates, hospital discharge data, WIC, and newborn screening files. MCH does not have direct access to data files for Medicaid Eligibility/Paid Claims Files, birth defects surveillance system data, and PRAMS-type data.

#09(B): The ability of states to determine the percentage of adolescents in the grades 9-12 that report using tobacco products in the last month. The Kansas State Department of Education has the CDC grant for the Youth Risk Behavior Survey (YRBS). Due to low participation by sampled schools the data are usually not reliable, however, this is changing and we expect to have reliable data for the 2004-05 school year. Another survey instrument used in Kansas is the Youth Tobacco Survey for which the sample size is adequate. The MCH program has indirect access to both databases for analyses.

#09(c): The ability of states to determine the percent of children who are obese or overweight. Kansas' capacity is fairly good. YRBS data are expected to improve through the work of Coordinated School Health and MCH has indirect access to the data. WIC program data are easily accessible and high quality. Pediatric Nutrition Surveillance System (PedNSS) data are readily available, high quality, but the data are collected only for WIC participants. The new foundation-funded Kansas Child Health Assessment Monitoring Project or K-CHAMP will collect BMI data on school children grades 6-12. Environmental data from participating schools will be gathered as well to examine the relationship between overweight and other factors: academics, attendance, nutrition behaviors, physical activity habits, screening time, and so forth.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

In Kansas as elsewhere, very high standards of accountability apply to all maternal and child programs. This is due to scarcity of resources at the federal, state and local levels and through other funding sources such as foundations. Legislators and others require regular reports on best practices, performance and outcomes. Increasingly data is linked to funding decisions, mostly to achieve efficiencies but also to improve outcomes for certain target populations. The State budget including the BCYF budget is based on performance and outcomes. The Legislature requires strict accountability through annual reports and special reviews. An example of a special review is the Legislative Post Audit study on KDHE programs that address low birthweight. Other funding sources such as the Children's Cabinet which provides oversight of Tobacco Settlement funds requires each recipient of funds to provide an annual program evaluation summary including performance and outcomes.

Since 1999 BCYF has included performance plans and performance information in its federal MCH budget submission. BCYF submits annual reports to Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) on the actual performance achieved compared to that proposed in the performance plan. This Section of the Kansas MCH Services Block Grant Application describes how the State-Local partnership will implement the federally-required performance reporting requirements.

The MCH Block Grant Performance Measurement System is an approach utilized by Kansas that begins with the state/local needs assessment and identification of priorities. It culminates in improved outcomes for the maternal and child population. After Kansas establishes its priority needs for the five-year statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH Pyramid: direct health care services, enabling services, population-based activities, and infrastructure building activities. Since there is flexibility available to Kansas in implementing programs to address priority needs, the program activities or the role that MCH plays in the implementation of each performance measure may be different from that of other states. Kansas can track its individual progress on up to ten unique State performance measures and Kansas can track its progress on eighteen national performance measures and compare its performance with the performance of other states using the Maternal and Child Health Bureau's Title V Information System.

Accountability in BCYF programs is determined in three ways: (1) by measuring the progress towards successful achievement of each individual performance measure; (2) by budgeting and expending dollars in each of the four recognized MCH services: direct health care, enabling services, population-based activities, and infrastructure-building activities; and (3) by having a positive impact on the outcome measures.

While improvement in outcome measures is the long-term goal, more immediate success may be realized by positive impact on the performance measures which are shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside BCYF control affecting the outcomes.

B. STATE PRIORITIES

The Kansas comprehensive needs assessment was completed in 2000. At that time ten priority needs were identified. This narrative will describe each priority need, Kansas' capacity and resources to address each need, and relationship(s) of each to the national and state performance measures.

1. Maternal and Child Health Access. Improve access to all aspects of primary health care for vulnerable populations. MCH grants are provided to local health departments that serve all 105 counties. The Healthy Start home visitor program goal is to visit all families with newborns to provide

education and support, and to link families with community services. Local health department staff persons assist women and children with applications for Medicaid and SCHIP, or otherwise assist them in establishing a medical home.

NPMs 13 (children without health insurance) and 18 (prenatal care in the first trimester) relate to this priority need.

2. Access for Children with Special Health Care Needs. Improve access to all aspects of health care for children with special health care needs (CSHCN). CSHCN supports a system of specialty clinics throughout the state, assists families with financial matters relating to the care of their children, and provides case management services to assure that families are able to access appropriate and quality services.

NPMs 2, 3, 4, and 5 relate to this priority need.

3. Disparities. Identify and reduce demographic and geographic disparities. A goal of MCH/CSHCN services is to eliminate health disparities among segments of the population including differences that occur by race/ethnicity, socio-economic status, disability or geographic location. Since the greatest opportunities for reducing health disparities are in empowering individuals to make informed health care decisions and in promoting community wide safety, education, and access to health care, MCH/CSHCN is committed to equity through equal access to comprehensive, culturally competent, community-based health care systems that are committed to serving the needs of the individual and promoting community health. Resources are used to assure a targeted approach to the needs of specific populations and the needs of specific communities.

All national outcome measures and most NPMs relate to this priority need.

4. Data, Epidemiology, and Analysis Resources. Increase data infrastructure, epidemiological capacity, and products of analyses for improved state and community problem-solving. The BCYF has shifted from reliance on external sources of epidemiological support to reliance on internal sources of support. Two epidemiology positions, one funded by the State Systems Development grant provide epidemiology support to BCYF programs and to special projects.

All national outcome and performance measures relate to this priority need.

5. Unintentional Injuries. Reduce injuries due to motor vehicle crashes, burns, firearms, and trauma among children. MCH collaborates with the KDHE Injury Prevention program in the Office of Health Promotion and with the state SAFE Kids Coalition regarding policy and program development. Local MCH agencies coordinate with local SAFE Kids coalitions on distribution of smoke detectors in homes of low-income families, child safety seat distribution and education for families, bicycle helmet promotion. Linkages with the state Poison Control Center assure statewide public health education for young parents on household safety measures.

NOMs 1, 4 and 6 and also NPM 10 relates to this priority need.

6. Intentional Injuries. Reduce violence among maternal and child health populations. MCH/CSHCN programs assure screening of mothers, children and youth including children with special health care needs during routine health care visits with referrals as appropriate. MCH/CSHCN coordinates with state programs that address domestic violence and child abuse. School programs address bullying and other behaviors.

NOMs 1, 2, 4, 6 and NPM 3 relate to this priority need.

7. Nutrition & Physical Activity. Reduce obesity and sedentary lifestyles, particularly among children and adolescents. BCYF programs that address nutrition and physical activity are coordinated through Nutrition and WIC services. The four nutritionists provide consultation to all programs relating to

nutrition issues. Nutrition and physical activity issues are addressed through collaborative work with the Coordinated School Health program. BCYF supports the annual Kansas Kids Fitness day at the Governor's mansion. Local MCH agencies are addressing nutrition and physical activity through local coalitions and in collaboration with schools.

NPM 3 relates to this priority need.

8. Oral Health. Develop oral health capacity at state and local levels. BCYF spearheaded an effort to reestablish an Office of Oral Health in KDHE. A dental hygienist was hired to link with the state oral health coalition, dental professional groups, workforce development, Medicaid coverage, and MCH/CSHCN programs at the state and local levels.

NPMs 9 and 14 relate to this priority need.

9. Behavioral Health. Develop behavioral health infrastructure. MCH/CSHCN have worked to improve linkages between public health and behavioral/mental health at both the state and local levels in order to address the needs of pregnant women, children and adolescents, and children with special health care needs.

NPMs 5, 6, 11, and 14 relate to this priority need.

10. Coordinated Systems of Care. Improve systems coordination and remove barriers caused by categorical programs and funding. Systems coordination efforts permeate all the work done in the BCYF. These efforts are process intensive and so all BCYF programs are challenged to identify opportunities for coordination.

All NOMs and NPMs relate to this priority need.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	99.9	99.9	100	100	100
Annual Indicator	99.5	98.6	100.0	100.0	100.0
Numerator	39032	38518	24	33	21
Denominator	39232	39052	24	33	21
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	100	100	100	100	100

Objective					

Notes - 2002

2002 Data Source: Kansas Newborn Screening program.

For the July 2003 submission the numerator and denominator changed to conform to the Detail sheet.

Notes - 2003

2003 Data Source: Kansas Newborn Screening program.

For the July 2003 and 2004 submissions the numerator and denominator changed to conform to the Detail sheet.

Notes - 2004

2004 Data Source: Kansas Newborn Screening program. Estimate based on 2003 data.

a. Last Year's Accomplishments

Direct Health Care Services:

CSHCN contracts provided statewide coverage for consultations on metabolic conditions. CSHCN purchased PKU formula and food products for individuals.

Enabling Services:

After an infant is 24 hours old, hospital personnel collect a blood spot specimen that is sent to the KDHE State Laboratory for processing. The Neonatal Screening staff at the State Laboratory then notifies the MCH Newborn Screening nurse of abnormal screening results. The NBS nurse, following lab criteria for requesting repeat samples, notifies the primary care physician (PCP) of the lab's findings. The PCP is also informed of consultation and referrals available through the CSHCN program. Parents are notified of the need to follow up with the PCP regarding abnormal screening results. The NBS nurse continues to provide case management services to assure that the infant has appropriate testing, diagnosis, referral and treatment services.

Infrastructure Building Services:

In February of 2005, the Governor announced the establishment of a Child Health Advisory Committee as part of the Healthy Kansas: Taking Steps Together initiative. The Committee consisting of 15 individuals from varied backgrounds will consider recommendations relating to the newborn screening program.

A proposal was forwarded to the KDHE Secretary requesting establishment of a task force to make recommendations regarding the expansion of NBS to include tandem mass spectrometry technology. The Secretary approved a review of the program.

Senate Bill 418 was passed in the 2004 legislative session. It established statutory authority for a birth defects surveillance system, however, no funding was appropriated.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nursing case management of infants with abnormal screens.		X		

2. Contracts providing statewide coverage for consultations on metabolic conditions.				X
3. Purchase of PKU formula and food products for individuals	X			
4. Arranging transportation, as needed, to access follow up services		X		
5. Data collection and reporting on NBS follow-up and congenital malformations.				X
6. Information to policy makers on MS/MS technology.				X
7. QA activities with hematology and endocrinology consultants.				X
8.				
9.				
10.				

b. Current Activities

Direct Health Care Services:

Same as last year.

Enabling Services:

Same as last year.

Infrastructure Building Services:

A grant was written in January 2005 requesting funds from the CDC to establish a birth defects surveillance
system. The grant was approved but not funded.

An application was submitted to the National Newborn Screening and Genetics Resource Center to conduct a review of the NBS program.

Seeking approval to utilize an on-line data entry system linked to the National Newborn Screening and Genetics Resource Center. The system allows immediate access to electronic data and statistics, decreasing the staff time required to complete these tasks.

c. Plan for the Coming Year

Direct Health Care Services:

Same as last year.

Enabling Services:

Same as last year.

Infrastructure Building Services:

In August of 2005 the National Newborn Screening and Genetics Resource Center will conduct a review of the Kansas NBS Program at the request of the KDHE Secretary. The review will be performed by a team of experts in newborn screening laboratory management, follow-up administration, medical follow-up, and quality assurance. The review will assess the functions of the current NBS Program and determine the program's capabilities in expanding services to include tandem mass spectrometry.

Update the NBS procedure manual to reflect the current procedures and post on the web page. Initiate quality assurance (QA) activities relating to the NBS program. Engage in regular meetings with the hematology and endocrinology consultants to facilitate QA, problem solving and exchange of current information. Utilize consultant's expertise to update the NBS policy manual. Review progress towards HP 2010 objectives.

All documents and educational pamphlets sent to physicians will be reviewed, including letters informing physicians of abnormal NBS results and report forms. Changes made will facilitate increased compliance by the physicians in reporting information to the NBS program.

Provide assistance to the MCH Director in organizing technical assistance on expanded newborn screening. Provide support and consultation to this process as requested.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			60	60	60
Annual Indicator			59.1	59.1	59.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	65	65

Notes - 2002

2002 Data Source: State estimates from the CSHCN national survey (SLAITS).

Notes - 2003

2003 Data Source: State estimates from the CSHCN national survey (SLAITS). The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

2004 Data Source: State estimates from the CSHCN national survey (SLAITS). The data reported in 2002 have pre-populated the data for 2003 and 2004 for this performance measure.

a. Last Year's Accomplishments

The data were extrapolated from the National CSHCN survey. The Kansas goal is that 60% of families served will report satisfaction with services and partnering in decision making. When

the survey is repeated in 2005 we will be able to measure any gains. According to the national survey of CSHCN, 59.1% of Kansas families partnered in decision-making compared to 57.5% for the U.S.

Direct Health Care Services:

When children are seen in CSHCN multidisciplinary clinics families are involved in the evaluation in order to voice concerns and work with the team when recommendations are made. SHS staff members are included in the multidisciplinary clinics and assist families with various appointments prior to and after the clinic visits in order to use the family's time more efficiently.

Enabling Services:

CSHCN staff work with families in the development of health care plans, which are used to outline care coordination. Families help to identify the providers used for services. When families use a provider that is not a contracted provider, staff will work to get a new provider identified or work with the provider to become a contracted provider for the CSHCN program. Providers can include: hospitals, labs, primary care physicians, specialists and interpreters. Families are notified of resources and services available in their local communities. Our toll free number for families has a bilingual message for both English and Spanish speaking families. We have interpreter services in place to assist when the families call. Sign language interpreters have been provided in the multidisciplinary clinics when requested.

Population-Based Services:

Families involved with the early intervention program are involved in the development of the Individual Family Service Plan. Families are also involved in the development of Individual Education Plans from ages 3-21. When families report difficulty in obtaining services from school districts, families are referred to the Kansas Parent Training and Information Center, Families Together Inc.

Infrastructure Building Services:

Families Together staff continue to sponsor an advisory group for the CSHCN program. The advisory meetings are held on Saturdays with travel and lunch provided, or by conference call. Email has also served as a mechanism for communication for the advisory group.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review Health Care Plans with parents.		X		
2. Families are involved in decisions at multidisciplinary and specialty clinic appointments.		X		
3. A toll-free line is available for families to call regarding services and concerns. This will also be expanded to list resources on the internet.		X		
4. Families are given a choice of providers.		X		
5. A family advisory group assists the CSHCN program in policy decisions.				X
6. CSHCN staff assist families with identifying resources in their		X		

communities.				
7. Bilingual staff person hired by KDHE to assist with interpretation for families contacting KDHE programs.		X		
8. Families involved in CSHCN program strategic planning meeting and grant submission.				X
9.				
10.				

b. Current Activities

The CSHCN program continues to partner with families as above.

Enabling Services:

KDHE has hired a bilingual staff person to assist agency personnel in providing services to the Spanish speaking population of Kansas. She is available to both interpret and translate materials.

Population-Based Services:

SHS staff continue to be involved with Health Fairs and conference exhibits to educate parents and agencies about CSHCN services.

Infrastructure Building Services:

Family members and young adults with disabilities were members of the panel of experts convened to determine the CSHCN priorities for the MCH needs assessment and were stakeholders in the Champions for Progress meeting which the CSHCN program held to provide strategic planning. A youth with special health care needs has also been appointed by the Governor to be a member of the Special Bequest advisory commission. Family members were also used to assist in the development of the grant submission for The President's New Freedom Initiative: State Implementation Grant for Integrated Community Systems for CSHCN.

c. Plan for the Coming Year

The CSHCN program will continue to partner with families maximizing the use of the Families Together contract and using families and youth for advisory needs.

Infrastructure Building Services:

The advisory group will continue to assist in review of policies for the CSHCN program. The contract with Families Together will have new performance outcomes to help strengthen the use of the advisory group and families. It is anticipated that a new policy manual will be developed in the coming year. A family member will again join us as a representative of Kansas at the Champions for Progress Multi State Meeting. We will also have continued input from families related to The President's New Freedom Initiative: State Implementation Grant for Integrated Community Systems for CSHCN grant.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			60	60	60
Annual Indicator			58.9	58.9	58.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	65	65

Notes - 2002

2002 Data Source: CSHCN national survey (SLAITS) state estimates.

Notes - 2003

2003 Data Source: State estimates from the CSHCN national survey (SLAITS). The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

2004 Data Source: State estimates from the CSHCN national survey (SLAITS). The data reported in 2002 have pre-populated the data for 2003 and 2004 for this performance measure.

a. Last Year's Accomplishments

The data for this performance measure was extrapolated from the National CSHCN survey. The national CSHCN survey showed that 52.6% of U.S. families reported receiving care within a medical home, while 58.9% of Kansas families reported receiving care within a medical home. Kansas expects this average to be as high as 60% in the next survey. When the survey is repeated in 2005 we will be able to measure any gains.

The CSHCN data system cannot provide this data. Kansas CSHCN is soliciting bids on a new data system that will collect this data.

Direct Health Care Services:

The CSHCN program authorizes care for children eligible for treatment services when the child is seen by the primary care provider related to an eligible condition. A copy of the plan of care is shared with the child's primary care physician (PCP).

Enabling Services:

The CSHCN program provides assistance with transportation costs if the child lives more than 50 miles from an authorized provider. Program staff work with the families who are eligible for Medicaid/SCHIP services to educate them in the process of obtaining transportation reimbursement. The CSHCN program also entered into a formal agreement with an interpretation/translation service in order to help central/field office staff converse with families

who do not speak English. Interpretation services are also funded for families when they attend out-patient medical appointments. This service is authorized by care coordination staff. For those children who are assigned a PCP with Medicaid, CSHCN staff obtain a referral from the physician who is the PCP that serves as a referral for the length of the plan of care for authorized services. Medical reports are also shared with the child's PCP when they are received by SHS staff from medical specialist.

Infrastructure Building Services:

The CSHCN program uses providers that are board certified. For local care the providers will hold a license with the Kansas Board of Healing Arts. Pediatricians are required to be board certified in Pediatrics. Staff continue to be involved in the Oral Health Coalition and will work with the coalition on concerns of dental access for all children and those with special health care needs. The rural communities of Kansas also have severe access issues. Many children in the state who are covered by Medicaid/SCHIP have additional issues related to access, as they are unable to find providers who accept Medicaid/SCHIP coverage.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Referrals are obtained by CSHCN staff for Medicaid clients assigned to the PCCM program (medical home).		X		
2. Reports from the medical specialists are provided to the local primary care physician.		X		
3. Providers in Kansas are educated about CSHCN services.				X
4. CSHCN staff help the family to identify a local care provider when the family has not identified a medical home.		X		
5. CSHCN program provides interpreter services to assist families who are attending out patient medical appointments.		X		
6. Primary care providers receive a copy of CSHCN program Health Care Plans when they are developed.		X		
7. CSHCN program will use the Kansas AAP Child Health Advisory Council to assist physicians statewide in education related to medical home.				X
8. CSHCN program is developing a new data system that will track medical home components.				X
9.				
10.				

b. Current Activities

The program continues to support medical homes for children with special health care needs as above.

Enabling Services:

The Farm Worker Health Program in the state has hired Low German speaking interpreters to assist with this population of Kansans. As previously mentioned KDHE has also hired a Spanish interpreter/translator to assist KDHE staff. For those children who are enrolled in SCHIP or HealthWave XIX, the program has changed policy and no longer requires a PCP

referral when children see a specialist. We continue to work to authorize services for those providers who are not in the SCHIP network.

Infrastructure Building Services:

The state Infant-Toddler program continues to explore the use of the "Caring for Infants and Toddlers with Disabilities: New Roles for Physicians" (CFIT), and is working to obtain funding. CSHCN program staff have discussed partial funding of the project as it was not funded by a private grant. As a result of the Champions for Progress strategic planning meeting, CSHCN program staff worked to obtain funding from a local foundation to provide education in a three county area to childcare providers and local physicians regarding various topics including medical home.

c. Plan for the Coming Year

Infrastructure Building Services:

CSHCN staff will continue to investigate the use of the CFIT program in Kansas. We will also work with the three county area discussed above to determine if the project can be sustained. A Child Health Advisory Council has been formed with the Kansas AAP chapter and one important issue identified was access to a medical home for all children in Kansas including CSHCN. A new data system is expected to be developed in the next year which will include components to help track medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			65	65	65
Annual Indicator			63.9	63.9	63.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	70	70

Notes - 2002

2002 Data Source: CSHCN national survey (SLAITS) state estimates.

Notes - 2003

2003 Data Source: CSHCN national survey (SLAITS) state estimates. The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

2004 Data Source: CSHCN national survey (SLAITS) state estimates.
The data reported in 2002 have pre-populated the data for 2003 and 2004 for this performance measure.

a. Last Year's Accomplishments

In Kansas, 63.9% of CSHCN have adequate health insurance coverage according to the National CSHCN survey. This compares to 59.6% for the U.S. "Adequate private and/or public insurance" is defined as access to health services including preventive care, primary care and tertiary care. Many Kansas families have insurance policies that cover only well visits or catastrophic care. When the survey is repeated in 2005 we will be able to measure any gains.

Direct Health Care Services:

During multidisciplinary clinics, insurance coverage (public/private) is assessed. Families that are uninsured and are potentially eligible, are given information about Medicaid/SCHIP and the CSHCN program. They are encouraged to apply and/or they are assisted with the application process. The CSHCN program continues to be the sole source of coverage for numerous undocumented citizens. We continue to use the SHS program application to help determine if the applicant is a US citizen and/or here with legal documentation. Many families were filling out the Medicaid application but were not able to complete the application as they had no documentation. By adding questions to our CSHCN program application we can prescreen them for Medicaid eligibility.

Enabling Services:

Families that apply for the CSHCN program are required to apply for the State Medicaid/SCHIP programs, unless they are screened out due to citizenship status on the CSHCN program application. Medicaid/SCHIP applications are sent to each applicant (English or Spanish) depending on the families' language. The Medicaid/SCHIP applications are labeled with our program name and instructions for the Clearinghouse staff to figure a spenddown if the family is not eligible for SCHIP and over Medicaid income guidelines. A staff person has been designated at the Clearinghouse to work with the CSHCN program referrals. CSHCN staff contact the Clearinghouse to resolve problems when families report problems.

Infrastructure Building Services:

CSHCN staff ensure that billing has been completed with public/private insurance prior to CSHCN payment. CSHCN uses contracted providers that will take the CSHCN rate of payment as payment in full.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families applying for CSHCN program are required to apply for SCHIP/Medicaid programs.		X		
2. CSHCN program staff work closely with clearinghouse staff to assist families with Medicaid application process.		X		

3. CSHCN care coordinators work with families to identify local resources to assist with medical needs.		X		
4. CSHCN staff will monitor the legislative process with enactment of Pharmacy Assistance Program.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN program continues with the activities listed above.

Enabling Services:

Case managers work with local agencies and other State agencies to help families find assistance for services not covered by the CSHCN program.

Infrastructure Services Services:

In the 2005 legislative session, $750,000 was appropriated for a Pharmacy Assistance Program that would cover prescriptions through community health centers. CSHCN is establishing a referral mechanism for CSHCN families to apply for assistance.

c. Plan for the Coming Year

Enabling Services:

CSHCN will continue a close working relationship with Clearinghouse staff.

Infrastructure Building Services:

CSHCN staff will monitor legislative initiatives in the state of Kansas that may ease the financial impact of CSHCN on families.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			70	70	70
Annual Indicator			70.9	70.9	70.9

Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

Notes - 2002

2002 Data Source: CSHCN national survey (SLAITS) state estimates.

Notes - 2003

2003 Data Source: CSHCN national survey (SLAITS) state estimates. The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

2004 Data Source: CSHCN national survey (SLAITS) state estimates. The data reported in 2002 have pre-populated the data for 2003 and 2004 for this performance measure.

a. Last Year's Accomplishments

In the National CSHCN Survey, 70.9% of Kansas CSHCN families reported access to community-based service systems compared to 74.3% for the U.S. It is a challenge to assure that services are available in all rural areas of the state. When the survey is repeated in 2005, any gains will be measured.

Direct Health Care Services:

The CSHCN program supports services in the local community by encouraging outreach by our Specialists. Outreach clinics include pediatric cardiology, orthopedic, pediatric rheumatology, otolaryngology, audiology, and developmental pediatrics. An agreement is in place with the Kansas State Department of Education that helps to fund Special Child Clinics. The clinics are held throughout the state, with a multidisciplinary team that is organized based on each community's needs.

Enabling Services:

Interpretation services are also provided for families for whom English is a second language. This is authorized by care coordination staff.

Population-Based Services: The Kansas early intervention program is a frequent referral source for the CSHCN program. As the program provides services to children in a natural environment (child care center, home etc) the services are easy for the families to use.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN contract support outreach clinics.				**X**
2. CSHCN (ages 0-2) are referred to Part C early intervention networks in their communities.		**X**		

3. CSHCN (ages 3-21) are referred to local school districts for Part B services in their communities.		X		
4. Special Child Clinics are offered in local communities from interagency agreement with Department of Education.	X			
5. Interpretation services are funded for visits with local providers as needed.		X		
6. CSHCN staff will work with local communities to identify needs for specialty outreach and care coordination.				X
7.				
8.				
9.				
10.				

b. Current Activities

The program continues with the activities listed above.

Direct Health Care Services:

Special Child Clinics have assisted local communities in the diagnosis and treatment of many conditions such as autism. The waiting period to attend the tertiary centers for an autism diagnosis can be 6-9 months.

Infrastructure Building Services:

The CSHCN program convened stakeholders from across Kansas to develop a strategic plan for the program. The CSHCN program had applied for the President's New Freedom Initiative: State Implementation Grant for Integrated Community Systems for CSHCN grant to assist with increasing services in the local community and the development of regional office sites.

c. Plan for the Coming Year

Direct Health Care Services:

The CSHCN program will implement creative ways to strengthen community-based services. The President's New Freedom Initiative: State Implementation Grant for Integrated Community Systems was not funded in Kansas but we will look at developing regional offices and specialty services outreach for CSHCN after working with local stakeholders.

Infrastructure Building Services:

The program will continue to work with local partners such as infant toddler, education and physicians to ensure that services are available to special needs children.

With the addition of regional sites we will expand multidisciplinary clinics such as seating clinics to local communities. We will work with local communities to assess the need for regional offices and assess local strengths and weaknesses.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			5	5	5
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	15	15	15

Notes - 2002

2002 Data Source: CSHCN national survey (SLAITS) state estimates. Only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine uses its State value.

Notes - 2003

2003 Data Source: CSHCN national survey (SLAITS) state estimates. The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

2004 Data Source: CSHCN national survey (SLAITS) state estimates. The data reported in 2002 have pre-populated the data for 2003 and 2004 for this performance measure.

a. Last Year's Accomplishments

In the National CSHCN Survey, 5.8% of U.S. youth with special health care needs reported receiving services necessary to make transition to all aspects of adult life. This compares to 5.2% of Kansas youth with special health care needs, reporting adequate transition services. (The Kansas percentage was an estimate because it did not meet the NCHS standard for reliability or precision.) In Kansas, generally, the vocational/educational transition is more comprehensive than transition to adult medical services. When the survey is repeated in 2005, Kansas will be able to measure any gains.

Direct Health Care Services:

CSHCN staff have used the timeline that was developed by the CHOICES project to assist families with early transition issues from toddler age through adolescence. Some topics currently discussed at CSHCN specialty clinics include: guardianship at age 18 for those unable to make their own decisions; medical care in family practice after the child ages out of pediatric services; SSI/insurance/Medicaid coverage after age 21; independent living options if appropriate; post high-school education; possible referral to Rehabilitation Services (formally Vocational Rehabilitation) if appropriate.

Infrastructure Building Services:

CSHCN staff were members of the planning committee for an annual transition conference. Presentations have been done in the past related to "Transition in the Lifespan". Participants of the conference were broadly representative of the variety of disciplines that serve the youths who are transitioning including: transition counselors, vocational rehabilitation staff, parents, early intervention staff, special education staff and nursing staff. CSHCN staff also participated in focus groups sponsored by Kansas Rehabilitation Services for a Youth Referral Project.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Vocational Rehabilitation is used as a referral source for clients when necessary.		X		
2. Cystic Fibrosis and Cerebral Palsy clinics assist older adolescents in transitioning to adult services.	X			X
3. Transition issues are reviewed with families during clinics beginning in early childhood.		X		
4. Transition issues are addressed in the CSHCN plan of care.		X		
5. Attempts are made to locate services after children are no longer eligible for the CSHCN program.		X		
6. CSHCN staff participate in planning of statewide transition conference.				X
7. CSHCN staff will work with agencies in the development of a "transition tool".				X
8.				
9.				
10.				

b. Current Activities

The CSHCN program continues with the above activities.

Infrastructure Building Services:

Staff participate in planning for the "KansTran" conference. The main focus is education/vocational rehabilitation but CSHCN promotes a health care/medical component for each conference. CSHCN staff participate in the Kansas Commission on Disability Concerns (KCDC) in order to promote "Each student with a disability will receive adequate transition services to achieve independence and, if desired, post secondary education and employment." As a result of the strategic planning session, CSHCN staff have been working with other local agencies to develop a "Transition Tool" that is web-based and assist numerous agencies working with youth to address transition issues.

c. Plan for the Coming Year

Infrastructure Building Services:

Staff will continue to participate on the planning committee for the "KansTran" conference. The plan is to add a panel of staff from the multidisciplinary clinics and a panel of youths and young adults with special health care needs. Staff will continue to work on the transition tool and work with youth to address medical transition issues.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	80	80	80	80
Annual Indicator	76.5	76.7	74	78.1	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	82	84	84	86

Notes - 2002

2002 Data Source: National Immunization Survey, 2002. NIS Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, vaccination for Haemophilus Influenza type B and Hepatitis B were not required for school entry for the the survey years reported here, but recommended and may be under reported.

Notes - 2003

2003 Data Source: National Immunization Survey, 2003. National Immunization Survey Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, vaccination for Haemophilus Influenza type B and Hepatitis B were not required for school entry for the the survey years reported here, but recommended and may be under reported.

Notes - 2004

2004 Data Source: NIS data not yet available for 2004.

a. Last Year's Accomplishments

The Kansas Immunization Program (KIP) makes funding available to county health departments through grants to provide immunization services, purchase vaccines, and raise immunization rates.

According to the National Immunization Survey conducted by the Centers for Disease Control and Prevention (CDC), Quarter 3 - 2003 through Quarter 2 -- 2004, Kansas immunization rate for 19 to 35 month olds was at 79.1%, just 1% below the national average for the 4-3-1-3-3 vaccination series but remains well under the 90% goal set for immunization coverage by CDC and the National Childhood Immunization Initiative (CII).

Direct Health Care Services:

Most children received their immunizations from the local health department. Not all children in

Kansas have designated medical homes. Only a few children received their needed immunizations from their designated medical home provider.

Enabling Services:

Kansas Healthy Start Home Visitors (HSHVs) provided outreach and family support to families with new infants and young children. They provided immunization education and directed parents to resources in their communities.

Infrastructure Building Services:

In 2003, the Medicaid Outreach Project, a KDHE/SRS collaborative effort implemented in ten counties with low immunization rates, proved effective in improving rates. There was improvement of at least 10% in CASA rates (immunization reporting by local health departments) in 7 of the counties. The Governor's task force on immunizations studied the issue and made recommendations to: continue development of the immunization registry; change the age for administration of fourth dose of DTaP; expand the immunization reminder systems; expand the medical immunization outreach project; expand current WIC/KDHE partnership and expand access to childhood immunization through the child's medical home. Kansas regulations regarding Varicella and Hepatitis b series for kindergarten students went into effect.

The KIP, for the first time, offered grants for computers to Vaccine for Children (VFC) providers in the private sector in preparation for the immunization registry. Grants for refrigerators and freezers were also offered to VFC providers in the private sector to ensure proper storage and handling of vaccine.

KIP formed the Tri-State Regional Immunization Coalition (TRIC) to focus on raising immunization rates in Kansas, Missouri and Oklahoma. This coalition is conducting an immunization awareness campaign during National Infant Immunization Week (NIIW) through newspaper advertisements in this tri-state area.

October, 2003, vaccine guidelines were monitored to assure that the publicly provided vaccine was administered to the target population.

A contract for customization and installation of a statewide immunization registry was secured.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with schools & public health agencies to provide education on age-appropriate immunizations.				X
2. Provide technical assisstance and consultation on questions and problems regarding immunizations.				X
3. Continue interagency collaboration to maintain high levels of immunization for all children and youth through delegation agreements to administer vaccines.				X
4. Continue Medicaid outreach project for counties with low rates.		X		
5. Develop Immunization Registry to maintain accurate immunization records.				X

6. QA of vaccine service.				X
7. Kansas HSHVs continue outreach, provide immunization education, and support to families to help them get immunizations for their children.		X		X
8. Increase number of children receiving immunizations through their medical homes.	X			X
9. Birthing hospitals initiate birth dose of hepatitis B as VFC provider.			X	X
10. Expand use of PCV7(Prevnar) vaccine to underserved populations.	X			X

b. Current Activities

Direct Health Care Services:

Delegation agreements between Local Health Departments (LHD) and Rural Health Clinics (RHC)/Federally Qualified health Centers (FQHC) allow LHDs to vaccinate the underinsured child with VFC vaccine.

Resources permit the expansion of the use of PCV7 (Prevnar) vaccine to the underserved populations served by LHDs.

Enabling Services:

Kansas HSHV continue to provide outreach and family support to families with new infants and young children. They provide immunization education and direct parents in accessing those services within the community.

Population-Based Services:

In order to improve access to the birth dose of hepatitis B, birthing hospitals are being enrolled as VFC providers.

Infrastructure Building Services:

The Kansas Imminuzation Registry Project with multiple interfaces is being developed that will facilitate the exchange of immunization information among partners. Local health departments and private providers will be able to share this confidential patient-record data to track immunization status. The registry will capture and maintain immunization information from both private and public vaccination providers. Data is accurate, up-to-date and complete with all information pertaining to each individual consolidated into one non-duplicative history. Access to registry data will be authorized by KDHE and will strictly adhere to both state and federal mandates that protect the privacy and confidentiality of individual health information.

The KIP continues the provision of guidance and resources for the immunization of children. The Medicaid Outreach Project collaboration between KDHE and SRS has gone statewide, involving all of the local health departments and 101 private providers. KIP staff time is focused on improving access to immunizations in the child's medical home.

Vaccine for Children (VFC) provides immunizations for children whose insurance does not cover immunizations at participating federally qualified health centers and rural health clinics. By decreasing referrals to public health departments, the VFC program has improved the continuity of care and promoted the medical home concept.

It is anticipated that 15 public and 5 private immunization registry pilot sites will be initiated by the third quarter of 2005. A staff position has been added to assure training resources necessary for implementation of the statewide registry.

KIP is in the process of expanding the WIC/Immunization linkage project to counties serving the largest number of WIC clients, who also have the lowest immunization rates.

KIP is collaborating with the Kansas Academy of Family Physicians to increase the number of VFC providers and implement the immunization registry in private provider offices to support vaccine administration through the medical home.

c. Plan for the Coming Year

Direct Health Care Services:

Increased numbers of children will receive immunizations from their medical home providers.

Continued delegation agreements between local health departments and Rural Health Clinics (RHCs)/Federally Qualified health Centers (FQHCs) will allow LHDs to vaccinate the underinsured child with VFC vaccine.

Enabling Services:

The KDHE immunization registry will generate reminders that vaccines are due. These will be mailed to parents.

Kansas Healthy Start home visitors (HSHV) will continue to provide outreach and family support to families with new infants and young children. They will provide immunization education and help parents find those services in their communities.

Population-Based Services:

Birthing hospitals will initiate the birth dose of hepatitis B vaccine before the infant is dismissed from the facility as a newborn.

Infrastructure Building Services:

KDHE will continue to provide guidance and resources for childhood immunizations. Increasing costs of vaccine purchase will require monitoring of resources and their usage to assure that public vaccine supplies meet the needs of the intended population.

The KIP will continue implementation of the statewide immunization registry. This statewide immunization registry will access multiple sources of electronic immunization data and result in a useful source of immunization data for healthcare providers. In addition, the registry will assist in the management of vaccine supply and more effectively reduce wastage.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	22	22	20	20	20
Annual Indicator	22.6	22.5	21.2	20.0	
Numerator	1377	1368	1262	1174	
Denominator	60839	60839	59521	58677	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	19	19	18	18	18

Notes - 2002

2002 Data Sources: Kansas Vital Statistics, 2001 resident data (numerator) and U.S. Census estimates (Bridged-Race Vintage data set)(denominator).

Notes - 2003

2003 Data Sources: Kansas Vital Statistics, 2002 resident data (numerator) and U.S. Census estimates (Bridged-Race Vintage data set)(denominator).

Notes - 2004

2004 Data Sources: Birth certificate data for 2004 is not currently available. The Office of Vital Statistics estimates that the data will be released September of 2005.

a. Last Year's Accomplishments

National data from 2003 indicates a birth rate of 22.4/1000 females ages 15-17. In 2003, Kansas data showed a birth rate of 20.0/1,000 teenagers ages 15-17, slightly below the national rate. Kansas teen birth rate has shown a steady decline since 1995 except for the Hispanic population. The Hispanic teen birth rate for 2003 was 65.9/1,000 population.

Direct Health Care Services:

Through the Comprehensive School Health Center initiative, one local project provided accessible adolescent-focused contraceptive services.

Enabling Services:

Through the Comprehensive School Health Center initiative, one local project provided accessible adolescent-focused sexuality and contraceptive education. Six teen pregnancy prevention projects provided sexuality education. Six case management projects continued to provide comprehensive services to Medicaid teens under age 21 who are currently pregnant or parenting one child.

Population-Based Services:

School and community based education was provided through the Teen Pregnancy Reduction Projects and Peer Education Projects These projects targeted youth ages 10-17 emphasizing the value of postponing sexual intercourse.

Two Disparity projects address teen pregnancy rates for racial and ethnic groups in Sedgwick County (teen pregnancy for urban black youth) and in SW Kansas (teen pregnancy for rural Hispanic youth). These projects worked with the community to improve and strengthen families and youth by providing educational information, support group services, mentoring, family

preservation and support, and leisure time activities for youth. The projects also sponsored and co-facilitated community asset building workshops for adults and youth and collaborated with the family planning program initiative.

Infrastructure Building Services:

The teen pregnancy prevention projects provided sexuality education to the Hispanic population using bilingual teachers, that whenever possible, were from the local communities.

Kansas continued its participation in the Abstinence Only Education program under Section 510 of Title V of the Social Security Act. Requirements for participation included the administration of the Youth Risk Behavior Survey (YRBS) to adolescents in order to obtain consistent, current statewide data on adolescent risk-taking behavior, to monitor impact of programs, and to use in policy and program development.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Address reproductive health issues through Comprehensive School Health Centers.	X	X		X
2. Maintain Teen Pregnancy Prevention, Peer Education, and Case Management projects.		X	X	
3. Continue Teen Pregnancy Prevention projects that address disparities in teen pregnancy for Black and Hispanic youth.		X	X	X
4. Maintain and assure Abstinence Only education through local projects.			X	X
5. Encourage participation in YRBS.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Health Care Services:

The Comprehensive School Health Center initiative funds one project that delivers contraceptive services within a school-linked framework as appropriate.

Enabling Services:

The Comprehensive School Health Center initiative funds one project that delivers sexuality and contraceptive education and contraceptive services within a school-based framework. The other projects provide classroom-based and individual sexuality education and refer youth to other community agencies for contraceptive services as appropriate.

The Teen Pregnancy Program Case Management projects provide case management services to Medicaid teens under age 21 who are currently pregnant or parenting one child. The goals of the program are to reduce the incidence of repeat pregnancies and to reduce welfare

dependency. In order to achieve these goals, case managers work with clients on eight life domains: family planning and health, finances, education/training, employment, parenting, key relationships, daily living and empowerment. These projects assist adolescents to access community resources and services. They enable teen mothers to complete life goals and to become self-sufficient.

Population-Based Services:

Teen pregnancy reduction and peer education projects provide educational programs to encourage youth to delay initiation of sexual activity to decrease teen pregnancy rates. All current local projects, including disparity projects, continue in targeted geographic areas.

The Comprehensive School Health Center Initiative funds five local projects that deliver school-based medical services and health education including human sexuality to the middle and high school aged youth.

Infrastructure Building Services:

Kansas continues its participation in the Title V Section 510 Abstinence Education program for a new five-year cycle (FFY03-07). The program promotes abstinence until marriage. A requirement of the program in Kansas is that the projects encourage school districts in their areas to administer the YRBS so consistent data can be obtained regarding adolescent risk behavior and measure change over time. Grant funding is allocated to eight community projects through a competitive application process.

Regional Workshops on Human Sexuality and HIV/AIDS/STDs Education and Abstinence Only Education are being delivered through collaboration with the Adolescent Health, Abstinence Education, and HIV-STD Consultants in KDHE, and the Health and Physical Education Program Consultant in the Kansas State Department of Education. The purpose of these workshops is to ensure that all teachers of human sexuality and HIV/AIDS/STDs education have current medically accurate information and sensitivity about these topics, including abstinence only education.

c. Plan for the Coming Year

Direct Health Care Services:

KDHE will continue the Comprehensive School Health Center initiative for direct health care services and will expand school-based contraceptive services where possible.

Enabling Services:

Through the Comprehensive School Health Center Initiative, the Adolescent Health Consultant will promote delivery of classroom-based and individual sexuality and contraceptive education and contraceptive services within a school-based framework. Projects will refer youth to other community agencies for contraceptive services as appropriate.

KDHE staff will provide education and information in case management projects on inclusion of fathers. Teen Pregnancy Prevention will partner with other state agencies to offer the Fatherhood Summit annual conference and other bureaus within KDHE to offer the Minority Health annual conference and Public Health Nurse/MCH Staff Conference to address disparities in teen pregnancy for Black and Hispanic youth.

The teen pregnancy case management (TPCM) projects will continue to serve Medicaid teens

under age 21 who are currently pregnant or parenting one child. The goal of this intervention is to help teens increase interbirth spacing and/or delay subsequent pregnancies until goals are reached relating to education and economic self-sufficiency.

Population-Based Services:

KDHE will continue the teen pregnancy prevention projects and explore possible modification of teen pregnancy reduction and peer education projects to expand the developmental assets model.

Staff will continue to look at the culture of the Hispanic community in counties with high Hispanic teen pregnancy rates and explore options to provide the young adults with formal instruction on reproductive health issues.

Infrastructure Building Services:

KDHE will continue Abstinence Education programs and expand collection of YRBS data. The Adolescent Health Consultant will also continue to add the adolescent developmental asset building framework to the teen pregnancy prevention and peer education models by incorporating the concepts at the state and local levels from the Improving the Health of Adolescents & Young Adults: A Guide for States and Communities.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	46	50	50	50	50
Annual Indicator	NaN	45.6	45.1	45.1	34.2
Numerator	0	204233	196208	196208	11485
Denominator	0	447880	435052	435052	33558
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	36	36	37	37	37

Notes - 2002

2002 Data Sources: Behavior Risk Factor Surveillance System (numerator); U.S. Census estimate 2002 (denominator).

1999: 1999 BRFSS; 2000: Zero is entered - The question was not asked in 2000; 2001: 2001

BRFSS; 2002: 2002 BRFSS; 2003: The question was not asked in 2003, therefore data listed in 2003 are estimates based on 2002. 2004 data is based on the open mouth survey of Kansas 3rd graders called Smiles Across Kansas.

2000 Census estimate was used as denominator for 1999-2001 data. 2002 Census estimate was used as denominator for 2002.

Percentage represents percent of children ages 7-17 who have ever had dental sealants placed on their teeth (as reported by an adult respondent, weighted to represent children in population).

Notes - 2003

2003 Data Sources: Estimate based on 2002 BRFSS data.

Notes - 2004

2004 Data Sources: ASTDD survey of Kansas third graders called Smiles Across Kansas (numerator); U.S. Census estimates (denominator)

a. Last Year's Accomplishments

The data reported from the Smiles Across Kansas 2004 report, an open mouth survey using the Basic Screening Survey recommended by the Association of State and Territorial Dental Directors.

Direct Health Care Services:

The state of Kansas is currently not directly involved in placing sealants on children's teeth.

Enabling Services:

The Deputy Dental Director secured a HRSA grant of $50,000 for three years from 2004 -2007 to fund a school-based dental sealant project for second and sixth grade students in the Flint Hills Community Health Centers (FHCHC) catchment area, which includes Lyon, Chase, Greenwood, and Osage counties.

Infrastructure Building Services:

An open mouth survey of a representative sample of over 1, 000 Kansas 3rd graders provided data on the oral health status of Kansas children. The survey report, Smiles Across Kansas 2004, shows that 34.2% of children had at least one protective sealant on a permanent molar. The survey provides Kansas with baseline data from which to measure progress.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide non-dental professionals fluoride varnish training.		X		X
2. Provide leadership to the Oral Health Kansas coalition.				X
3. Provide leadership to the Kansas Public Health Board and Oral Health Section.				X
4. Provide technical assistance to the nurse DIAGNOdent screening project.		X		X
5. Provide technical assistance to the March of Dimes Program Services committee.		X		X

6. Provide technical assistance to the Kansas Child Care Training Opportunities Filling the Gap curriculum and video for child care providers.		X		X
7. Provide technical assistance to the Kansas Action for Children media campaign.		X		X
8. Provide consultation to the Early Head Start Initiative to help keep infants and toddlers children caries-free.		X		X
9.				
10.				

b. Current Activities

Enabling Services:

The Deputy Dental Director serves in an advisory capacity for an ABCD project, also as a Board member on the Oral Health Kansas coalition and Kansas Public Health Association. The Oral Health Kansas coalition consists of over 130 individuals and organizations including Head Start, private foundations, private insurers, Medicaid, KDHE Office of Oral Health, Dental Association and private dentists, Dental Hygienists Association and private hygienists, education and schools of medicine, low-income dental clinics as well as pediatricians. The strategic areas identified for coalition efforts are: access to care, prevention, oral health status, oral health leadership and workforce development.

The Deputy Dental Director provides consultation and technical assistance to Head Start and Early Head Start on oral health education and prevention services targeting 1,200 children in 34 counties. Providers learn about screening for signs of dental decay, fluoride varnish applications, and age-appropriate oral hygiene practices.

An innovative research project involving Kansas school nurses is underway. Currently, 89 school nurses have received training with a non-invasive laser fluorescent dental device (DIAGNOdent) to screen students for dental caries within their school districts. Children are referred as needed to local dentists and the nurses act as case managers to assure follow-up treatment. Additionally, 43 Public Health Nurses are included in the $200,000 total grant from United Methodist Health Ministry Fund to receive training from the Deputy Director on the use of the DIAGNOdent machine to facilitate oral screenings as part of their Early and Periodic Screening Diagnostic Treatment (EPSDT) Kan-Be-Healthy exams at the local health departments. A total of nearly 6,000 children are expected to be counted in the database in this year's results of children age 5 to 21 who receive an oral health screening.

Fluoride varnish training will be offered to this target population as well but currently only local health departments may be reimbursed by Medicaid for fluoride applications. The preventive procedure of fluoride varnish may be applied at the "well-baby" or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) exam along with oral health education and anticipatory guidance for the caregiver. This reimbursement issue for private practice physician's offices should be resolved by the Fall of 2005.

The Deputy Director, in conjunction with the Kansas Child Care Training Opportunities (KCCTO) office developed an oral health curriculum and video for providers of care to children birth to 5 (www.kdhe.state.ks.us/ohi/ccp_oral_health_info.html). The "train the trainer" sessions will be provided for the 200 community-based trainers and 100 area sponsors.

c. Plan for the Coming Year

Enabling Services:

KDHE is piloting a dental sealant project that will build on the extended care permit that allows a dentist to sponsor up to five dental hygienists in public health settings. KDHE is piloting a school-based dental sealant program that will target 2nd and 6th grade students in the Flint Hills Community Health Center's (FHCHC) catchment area, which includes Lyon, Chase, Greenwood, and Osage Counties. It will increase enrollment in Medicaid and SCHIP (HealthWave) programs, provide dental screenings, prophylaxis, sealants, fluoride varnish, "ToothPrints" identification, and oral hygiene instruction. This project will provide a local oral health delivery system of services and build capacity to help address the problems associated with a large number of children eligible for Free and Reduced Lunches and the limited number of dental Medicaid / SCHIP providers.

Kansas State Department of Social and Rehabilitative Services (SRS) and FHCHC will recruit and enroll families eligible for Medicaid or SCHIP by placing personnel at school open enrollment. This on-site service will help overcome the barrier of lack of transportation and insurance affecting access to dental care. This program will provide invaluable assessment and surveillance information with regard to state oral health policy development. It will build coalitions and partnerships with schools and collaborative systems with local dental providers, managed care plans, the community health center, and other organizations to assure the establishment and sustainability of caries prevention within these pilot schools and communities.

A comprehensive media campaign was launched by Kansas Action For Children (KAC), designed to increase awareness of children's oral health issues. This effort was made possible with the support of The United Methodist Health Ministry Fund, Delta Dental Foundation of Kansas, KDHE, and Kansas Dental Charitable Foundation. The domain name, www.yourmouthmatters.org, speaks directly to the importance of good dental health in the overall health of a child. On the website are several facts related to dental health including how it is directly linked to success in school, how certain readily-available foods and beverages contribute to the problem, and how simple prevention strategies and healthy food options can foster good oral health. A series of direct mail postcards have been developed focusing on a broad range of long-term oral health issues. The postcards are targeted to policymakers, influentials, and frequent voters. Also, an oral health "growth chart" detailing the developmental milestones for oral health care has been provided to pediatricians, family practitioners, school nurses, and child care providers for distribution to families with children.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5	5	5	5	5
Annual Indicator	5.3	6.1	5.1	5.4	
Numerator	31	36	29	31	
Denominator	588300	588300	573837	574120	
Is the Data					

Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	4	4	4	4

Notes - 2002

2002 Data Sources: Kansas Vital Statistics, 2001 resident data (numerator); U.S. Census 2000 data (denominator).

Notes - 2003

2003 Data Sources: Kansas Vital Statistics, 2003 resident data (numerator); U.S. Census estimates 2003 (denominator).

Notes - 2004

2004 Data Sources: Data is not currently available. The Office of Vital Statistics estimates 2004 data will be released September of 2005.

a. Last Year's Accomplishments

In Kansas, 1999-2003, the rate of deaths due to motor vehicle crashes has fluctuated in children ages 0-14. However, in 2003 the rate (5.4 100,000) was 14.3% lower than 1999.

The 2004 Annual Report on Child Deaths (2002 overview) published by the State Child Death Review Board showed that 75 of the 79 motor vehicle deaths (ages 0-17) were preventable. Unintentional injury was the cause of 39% of deaths in children ages 1-14, with 59% of these deaths classified as vehicular.

Direct Health Care Services:

Kansas Safe Kids distributed 4727 free CPS and booster seats, with 65 of these being distributed from local health departments. There are 568 CPS technicians, including 42 Healthy Start Home Visitors, and 28 volunteer CPS technician instructors covering 86 of 105 counties.

Enabling Services:

Kansas HSHVs provided outreach, education, and family support to pregnant women and families with new babies emphasizing the importance and necessity of using CPS, booster seats and seat belt usage in preventing injury and death. Some local health departments provided child safety seat low-cost rental and exchange programs for CPS and booster seats.

Population-Based Services:

Kansas Healthy Start Home Visitors, funded partially by MCH grants to local health departments informed families with new babies of the law, KSA 8-1344, and directed them to resources to help them acquire the appropriate CPS needed for their children.

Infrastructure Building Services:

Office of Health Promotion (OHP), KDHE, provided leadership for the agency in injury prevention through the Kansas SAFE KIDS network that consisted of 5 local SAFE KIDS Coalitions and 25 local chapters. Kansas SAFE KIDS has a multifaceted approach toward injury prevention through policy initiative endeavors to influence laws, regulations and institutional policies that affect childhood safety and increase funding support for injury programs and research. OHP also developed the role of an Emergency Medical Services for Children Coalition Program Coordinator to improve the emergency care and pre-hospital

transport of children across the state, improve injury data collection, and provide medical provider training, public information and education that includes injury prevention. The BCYF Child & School Health Consultant served as a member of this newly formed coalition.

Kansas SAFE KIDS introduced a legislative proposal to upgrade the existing Child Passenger Seats (CPS) law to require booster seats for children ages 4-8 and extend seat belt requirements for adolescents ages 14-18. Despite their sincere and eloquent support, the motion failed to pass legislative approval.

Kansas SAFE KIDS was named the National Coalition of the year in 2004 for their dedication to preventing unintentional injuries to Kansas' children ages 0-14. The unintentional injury death rate for children ages 0--14 in the ten years following the inception of Kansas SAFE KIDS has decreased 24% when compared to the previous ten years.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation in the Kansas SAFE Kids Coalition.				X
2. Collaboration with the Kansas Dept of Transportation data collection to target injury prevention efforts to match community needs.				X
3. Participation on the Emergency Medical Services for Children Coalition to assist in coordination of pediatric injury treatment and prevention educational programs targeting community level child health providers and school nurses.				X
4. Support of Kansas' trauma system's revision of criteria for reporting all children injured and admitted to a hospital.				X
5. Child Death Review Board analysis of deaths of children ages 1-14 that are involved in motor vehicle crashes.				X
6. Legislation supporting expansion of child passenger restraint law				X
7. Train Healthy Start Home Visitors (HSHV) as child passenger seat technicians in select counties with distribution of car seats at no-cost or low-cost.	X	X		X
8. Monitor local health departments' evaluation of local injury data assessment, and provide education and services to reduce the motor vehicle unintentional injury rate.				X
9. HSHV provide outreach, education, and instruction to families with infants and young children on importance of proper Child Passenger Safety.	X	X	X	
10.				

b. Current Activities

Direct Services:

Kansas Safe Kids Coalition distributed 1,242 CPS seats, including 187 infant, 456 convertible and 599 booster seats across the state using 39 local health departments as the primary site of distribution.

Enabling Services:

HSHVs continue outreach and family support to provide injury prevention information and education, including current laws, correct use and installation of car seats, booster seats and seat belts to the 15, 937 families they visit.

Staff turn-over has reduced the number of certified Child Passenger Seat (CPS) technicians to 525 in 81 Kansas counties. However, the Kansas Seat Belt Office is diligently providing trainings to increase this number. 134 of these technicians have made their information available on the National SAFE KIDS website to enhance their availability for referral and resource.

39 MCH monitoring visits were made to local MCH agencies that are targeting reduction of unintentional injury for the child and adolescent population served.

Population-Based Services:

Currently 28 MCH local health department grantees are implementing outcome-based strategies to reduce injury and death in the child and adolescent population with regard to CPS and seat belt usage. Kansas HSHVs continue to target families with new babies to inform about CPS laws and direct them to available community resources.

BCYF supports Kansas Trauma System efforts to require hospitals to report data on all children 0-14 who have specific injury diagnosis, including emergency department visits. Currently, this data is only collected for children who are admitted to the hospital, or transferred between hospitals.

To engage public health nurses and school nurses who interact with young Kansans, the Kansas Department of Transportation (KDOT) provides professional education to nurses about results of the Drunk Driving Prevention Survey administered to Middle/Junior High and High School students each year. This revealing survey assesses attitudes and behaviors of underage alcohol use, crash information.

Infrastructure Building Services:

BCYF staff continues collaboration with the OHP in Kansas SAFE KIDS and Emergency Medical Services for Children coalitions, to coordinate pediatric injury treatment and prevention educational programs across the state targeting community level child health providers and school nurses.

Kansas SAFE KIDS continues to advocate upgrade of Kansas's restraint laws for children with the re-introduction of HB 2109 which requires booster seats for children ages 4-8 and extends seat belt requirements for adolescents ages 14-18. A $60 fine, waived if the driver of the vehicle provides proof to the court they have purchased or acquired the approved child passenger safety restraining system, is the penalty to be applied. This proposed law includes a phase-in period to allow for the public to be appropriately educated on the new requirements.

c. Plan for the Coming Year

Direct Health Care Services:

Kansas Safe Kids Coalition will continue to supply and distribute free CPS and booster seats through CPS clinics and check points across Kansas. Proper installation of car seats will be provided either directly or by referral from Healthy Start Home Visitors ensuring motor vehicle injury prevention is occurring throughout the state

Enabling Services:

HSHVs will continue to provide outreach, education, and support to families they visit.

BCYF staff will continue to collaborate with KDOT, Kansas SAFE KIDS and EMSC coalitions to ensure increasing numbers of CPS technicians are trained. Additional HSHVs will receive training to become CPS technicians, and expand this service to families in all 105 Kansas counties.

Population-Based Services:

Local health department nurses and school nurses will join in the effort to provide injury prevention education about the importance of booster seat and seat belt usage information to parents of children over 4 yrs., and to school aged children and adolescents.

BCYF staff will collaborate with Coordinated School Health Initiative projects to include proper passenger restraint education and surveillance of the school-aged population of daily restraint usage while riding in private vehicles.

Infrastructure Building Services:

The recent Kansas 2010 MCH 5-year Needs Assessment identified injury reduction as one of three priorities to be addressed for the Child and Adolescent populations for the next five years. The focus of this priority is preventable injuries, both intentional and unintentional injuries. Over 30 of 87 local MCH agencies have selected injury prevention as a priority for the coming year and have developed objectives and activities to address the priority. CPS and seat belt usage will be primary activities for local agencies.

BCYF staff will collaborate with SAFE KIDS and EMSC coalitions to provide information and education to Kansas school nurses and community level child health providers to improve the Kansas emergency care system for children. As well, nurses will implement prevention focused education and interventions into their practice settings.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	75	75	75	75	75
Annual Indicator	73.4	73.8	72.2	70.7	
Numerator	28796	28820	28630	28510	
Denominator	39232	39052	39654	40326	
Is the Data					

Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	76	76	76

Notes - 2002

2002 Data Source: CDC Pediatric Nutrition Surveillance System (PedsNSS), Kansas WIC Program. Recently, CDC revised its guidelines on how PedNSS breastfeeding data are evaluated. In so doing, CDC reevaluated national and state breastfeeding trends. Now, when multiple records are submitted for a child during the reporting period, CDC creates a unique child record that contains some data from all available records. Also, the breastfeeding rates only look at children born during the reporting year. These changes affected the breastfeeding rates for 2001 and past years for both Kansas and the U.S.. Currently, Kansas does not include a breastfeeding question on its certificate of live birth and so there is no Vital Statistics data on breastfeeding at hospital discharge.

Notes - 2003

2003 Data Source: Ross Laboratory Survey 2003 (numerator); Vital Statistics, occurrent births 2003 (denominator).

Notes - 2004

2004 Data Source: Currently , data is not available for either the numerator or denominator. The Center for Health & Environmental Vital Statistics, KDHE, estimates 2004 data (denominator) will be released September of 2005.

a. Last Year's Accomplishments

Enabling Services:

Facilitated local breastfeeding coalitions across the state to work together to identify resources to increase breastfeeding rates.

Population-Based Services:

Information was sent to all WIC Breastfeeding Coordinators regarding the HHS Breastfeeding campaign. They were encouraged to contact local media to encourage the use of the HHS PSAs.

Infrastructure Building Services:

Facilitated discussion of LHD staff in eight counties to evaluate and develop breastfeeding strategies. Staff from a variety of programs within the LHD attended.

Healthy Start Home Visitors are in an ideal position to talk to new mothers during pregnancy. All were trained during regional meetings. The focus of the training was to help them promote the benefits of breastfeeding, identify problems and know where to refer within the community.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support community breastfeeding coalitions by encouraging LHDs to play an active role.				**X**

2. Communicate breastfeeding information to a variety of state and community agencies.				X
3. Continue collaboration with the Kansas AAP Breastfeeding Coordinator.				X
4. Collaborate with the Perinatal Association of Kansas to promote breastfeeding through Kansas hospitals.				X
5. Disseminate breastfeeding newsletter for LHDs to send to community contacts.				X
6. Support LHDs through WIC and MCH to continue and implement their breastfeeding action plans.				X
7. Provide self-instruction module on breastfeeding promotion for LHDs.				X
8. Increase breastfeeding knowledge of LHD staff for both MCH and WIC programs.				X
9.				
10.				

b. Current Activities

Population-Based Services:

Continue the coordination of World Breastfeeding Week (WBW) in August 2005. This will again include a packet to all local agencies with ideas to help with the promotion of WBW.

Infrastructure Building Services:

Two communities have scheduled Certified Breastfeeding Educator training for hospital, health department and home visitor staff. This will increase the level of expertise in both communities. The trainings have been publicized to surrounding communities.

MCH and WIC state level staff are working together to develop a group of LHD staff to help in the review of current breastfeeding practices and to develop best practices suitable for Kansas communities.

The reformatted Kansas Live Birth Certificate includes the question on the U.S. Standard Certificate of Live Birth - Is Infant Being Breastfed? Yes or No. Local hospitals started collecting this data on January 1, 2005.

c. Plan for the Coming Year

Infrastructure Building Services:

With the inclusion on the Kansas Live Birth Certificate of the breastfeeding question. We will be able to analyze data in ways that we have not had an opportunity to do. We plan specifically to look at the hospital data to see which Kansas hospitals have the higher breastfeeding rates and acknowledge their efforts.

The new WIC automation system has a feature where questions can be asked of specific types of participants (like pregnant or postpartum). In 2005 the questions will focus on the WIC client's perception of how breastfeeding was promoted at the LHD and within their community.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	98	98	98	98	98
Annual Indicator	90.9	92.4	90.4	95.3	96.0
Numerator	35644	36093	35862	38434	38828
Denominator	39232	39052	39654	40326	40449
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98

Notes - 2002

2002 Data Sources: Newborn Hearing Screening program, estimated on 3rd and 4th quarter data, 2002 (numerator); Kansas Vital Statistics, occurrent births 2000 and 2001 (denominator).

Notes - 2003

2003 Data Sources: Newborn Hearing Screening program, 2003 (numerator); Vital Statistics, occurrent births 2003 (denominator).

Notes - 2004

2004 Data Sources: Newborn Hearing Screening program 2004 (numerator); Vital Statistics occurrent births Provisional for 2004 (denominator).

a. Last Year's Accomplishments

Kansas has continued to screen at 90% or better since 2000. The percent of newborns screened before hospital discharge was 95% in 2003, an increase of 5%. This increase is related to an improvement by hospitals in reporting NICU infants that have the screening completed prior to discharge although it is may be much longer than the time period for well babies.

Enabling Services:

A contract to enhance the Parent-to-Parent program was renewed. The focus of the contract was on information resources available to parents including a booth at the Kansas Speech-Language- Hearing Association (KSHA) about early identification and resources. An in-service was provided to the Parent-to-Parent program staff.

Population-Based Services:

The screening is implemented at the local level by hospitals; birthing centers or other obstetrical/newborn services licensed facilities. Sound Beginnings administered the statewide system for newborn infant hearing screening, tracking, and follow-up.

Infrastructure Building Services:

The Sound Beginnings Advisory Committee continues to meet quarterly.

A newborn hearing screening informational brochure that is provided to families at the hospital is available in English and Spanish. A resource guide is also available for Audiologists and Early Childhood Special Educators to provide to families of infants and toddlers who have been identified with hearing loss.

Newborn Hearing Screening and EHDI programs and Pediatric Hearing Aid Selection and Fitting training were provided in collaboration with KSHA.

Training was provided by Christina Yoshinago-Itano for Early Intervention direct services personnel in collaboration with KSHA with a focus on intervention follow-through services, communication options, special populations form newborn hearing screening, assessment protocols.

Support through mini grants has been provided to remaining eligible hospitals for enhancing implementation of universal newborn hearing screening in hospitals.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue data submission through the web-based birth certificate (EBC) reporting system.			X	
2. Continue quarterly meetings of the Sound Beginnings Advisory Committee				X
3. Continue the education training to professionals on early interventio				X
4. Collaborate with the Families Together organization for parental input and parent to parent support.		X		X
5. Continue dissemination of Newborn Hearing Screening brochures for families to hospitals, etc.				X
6. Collaborate with OVS on implementation of web-based birth certificate reporting system				X
7. Rules and Regulations for Sound Beginnings program				X
8. Host a Family Conference				X
9.				
10.				

b. Current Activities

Enabling Services:

Collaboration with Families Together to enhance the Parent-to-Parent program services for families through the Audiologists and Infant-Toddler Services tiny-k networks. The focus areas continue to be on information resources available to parents, education of providers about the

program and support available for families.

Population-Based Services:

The screening is implemented at the local level by hospitals; birthing centers or other obstetrical/newborn services licensed facilities. Sound Beginnings administers the statewide system for newborn infant hearing screening, tracking, and follow-up.

Infrastructure Building Services:

Two additional birthing centers have been added and agreements with local Audiologists have been made to provide the screening. Eighty-nine percent (89%) of the birthing facilities are on the web-based birth certificate system that account for 99% of births reported on the web.

Hospital training for screening personnel was completed by a team consisting of a Neonatal Nurse, Pediatric Audiologist/Researcher and the Early Hearing Detection and Intervention (EHDI) Coordinator.

A newborn hearing screening workshop was offered for Pediatricians at their annual meeting.

A newborn hearing screening informational brochure that is provided to families at the hospital is available in English and Spanish. A resource guide is also available for Audiologists and Early Childhood Special Educators to provide to families of infants and toddlers who have been identified with hearing loss.

Continued submission of hearing screening results through the birth certificate system.

Continued submission of outpatient screening and diagnostic evaluation results through fax and mail.

First Family Conference in Kansas for families of newly identified infants and toddlers who are deaf or hard of hearing with keynote speaker Dr. John Dornhoffer, neurotologist who has hearing loss and is a father to a child who has hearing loss.

Sound Beginnings Newborn Hearing Screening Program Advisory Committee continues to meet quarterly. The Committee reviewed and provided feedback for regulations effective July 1, 2004. They continue to bring issues of concern from their constituents.

Follow-up to newborn hearing screening refer, missed, transfer and NICU results with parents and physicians. Continued work with providers to submit all outpatient and diagnostic reports to Sound Beginnings.

Senate Bill 511 passed which amended the existing law to provide statutory authority for the Secretary to carry out a screening program as proposed in rules and regulations, delete the word "significant" for detection of hearing loss since all degrees of hearing loss are significant and revised the timeline of within five days of birth for hearing screening.

c. Plan for the Coming Year

Enabling Services:

Continue collaboration with Families Together to promote the Parent-to-Parent program services to families, assist with the family conference, and assist parent consultants to start a Hands and Voices Chapter in Kansas, a support group specifically for families of children who are deaf or hard of hearing.

Population-Based Services:

The screening is implemented at the local level by hospitals; birthing centers or other obstetrical/newborn services licensed facilities. Sound Beginnings administers the statewide system for newborn infant hearing screening, tracking, and follow-up.

Infrastructure Building Services:

Continued submission of hearing screening results through the web-based birth certificate system and program the Sound Beginnings database to accept the new data fields on race, ethnicity, language spoken in the home, birth defects, and hospital transferred once the export process is operational from vital statistics.

Collaborate with the Kansas School for the Deaf, Infant Toddler Services, University of Kansas Deaf Education program, Infant Toddler networks, Hartley Family Program and the St. Joseph Institute for the Deaf oral program to provide training for personnel at tiny-k networks working with families of children identified with hearing loss and develop a regional program to assist in first contacts with families.

A Conference will again be offered in September to families of newly identified children who are deaf and hard of hearing.

Continued technical assistance provided to hospital personnel, Audiologists, Early Interventionists, Primary Care Physicians and other stakeholders of newborn hearing screening and intervention services.

Sound Beginnings Newborn Hearing Screening Program Advisory Committee continues to meet quarterly. The committee has established goals for the new Advisory year which begins July 2005 including parent communication and family concerns; focus on education to all members involved in early intervention and including the focus of the family perspective; and information sharing of legislative issues or advocacy from the Kansas Commission of the Deaf and Hard of Hearing or other organizations that are related to early hearing detection and intervention.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	6	6	5.5	5.5	5
Annual Indicator	10.9	7.7	8.0	6.4	
Numerator	74000	49000	57000	45000	
Denominator	676000	638000	711000	704000	
Is the Data					

Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	5	5

Notes - 2002

2002 Data Source: U.S. Census - Percent of children under 18 years not covered at any time during the year by some type of health insurance.
http://www.census.gov/hhes/www/hlthins.html (numerator)

Notes - 2003

2003 Data Source: U.S. Census - Percent of children under 18 years not covered at any time during the year by some type of health insurance.
http://www.census.gov/hhes/www/hlthins.html

Notes - 2004

2004 Data Source: Data is not yet available for 2004.

a. Last Year's Accomplishments

In 2003, 6.4% (U.S. Census) of Kansas children were without health insurance which demonstrates a declining trend; however, 44,000 remain uninsured which remains above the goal of 5.5%. This percentage rate has progressed from a high of 12.1% in 1999 to the current 6.4% uninsured in 2003.

Parents must reenroll their children on an annual basis otherwise their children's coverage is discontinued.

Enabling Services:

The Healthy Start Home Visitor (HSHV) program provided outreach and education to families with infants and young children on the availability of health insurance through referrals to the Medicaid/HealthWave program and assisted them with the enrollment process.

Comprehensive School Health Services projects are required to aid families in the completion of the application for HealthWave/Medicaid programs.

Population-Based Services:

Comprehensive School Health Initiative projects informed families of the Medicaid/HealthWave application process and aided them in the completion of the application form for the Medicaid/HealthWave program.

Technical assistance was provided to school health staff, nurses, social workers, and psychologists of the enrollment process and specifics about the Medicaid/HealthWave benefits and services. Schools were encouraged to provide information about Medicaid/HealthWave to parents at parent teacher conferences and school enrollment and to educate families of children who receive either free or reduced school lunches about their probable eligibility for Medicaid/HealthWave insurance coverage.

Infrastructure Building Services:

Due to budget reductions in SFY 2003, SRS consolidated its administrative regions from 11 to 6 thus closing 26 local offices where Medicaid/HealthWave enrollment previously occurred. This afforded an opportunity to establish over 300 "SRS Access Points" in communities across

the state to pursue more efficient ways of doing business while at the same time improving services to Kansans. SRS simplified and created a universal enrollment process between Medicaid/HealthWave and also placed the application on-line making application more accessible to Kansans.

The state MCH staff trained local health department staff to: assess client eligibility; inform families about the benefits of Medicaid/HealthWave participation; assist families to enroll (including on-line); and engage in public education efforts.

MCH staff provided follow-up on Child Health Assessment at School Entry (CHASE) reimbursement claims by local health departments to ensure that children were being assessed for Medicaid/HealthWave eligibility and families eligible but not enrolled were assisted with the enrollment process.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Children referred to Medicaid/HealthWave and establish a medical home.		X		X
2. Local health departments develop outcome-based plans to decrease the percent of children without health insurance in their regions.				X
3. Representatives convene to assess the integration of the applications for the free/reduced school lunch program and the Medicaid/HealthWave programs for school-aged children.				X
4. Link families with Medicaid/HealthWave by assisting with the enrollment application.		X		
5. Promote outreach activities in local education agencies by school nurses, school social workers, and school psychologists to enroll Medicaid eligible women and children.				X
6. Healthy Start Home Visitors assist families to enroll in Medicaid/HealthWave programs.		X	X	
7. Link students with Medicaid/HealthWave coverage through Comprehensive School Health Centers.		X	X	
8. Promote local coordination and collaboration between agencies to link hard-to-reach populations to Medicaid/HealthWave programs.				X
9. Collaborate with childcare professionals to link uninsured children to Medicaid/HealthWave programs.				X
10. Assist local health agencies to create a community plan for providing care for those uninsured children who remain ineligible for Medicaid / HealthWave programs.		X		X

b. Current Activities

Enabling Services:

Healthy Start Home Visitors will continue to assist families to enroll in Medicaid/HealthWave programs. Outreach efforts will be continued for hard-to-reach special populations to improve their access to quality health insurance. Local coordination and collaboration between agencies will be improved to eliminate gaps and duplication.

Population-Based Services:

Support and promote outreach activities in local education agencies to enroll Medicaid eligible women and children and to encourage their use of health services available to them under each program. Educate families of children who receive either free or reduced school lunches of their eligibility for Medicaid/HealthWave.

Require Comprehensive School Health Initiative grantees to assist families to enroll and re-enroll their children in the Medicaid/SCHIP (HealthWave) programs.

Infrastructure Building Services:

Local agencies are requested to develop outcome-based plans to decrease the percent of children without health insurance within their regions.

A task force of Social Rehabilitation Service, Kansas State Department of Education, and KDHE representatives convened to assess the integration and possible merger of the applications for the free and reduced school lunch program with the Medicaid/HealthWave program application for school-aged children. Identification of a medical home for each child is emphasized. Health insurance coverage is a critical component for children in assuring a medical home.

MCH staff work with Child Care Licensing and Registration staff to ensure that policies and procedures are in place to enroll eligible young children in Medicaid/HealthWave within the child care enrollment process. WIC programs are proceeding with plans to provide Medicaid/HealthWave outreach materials to their respective clients.

Local health department staff receive technical assistance and training to help families enroll their children in the Medicaid/HealthWave programs and enable them to counsel clients in the best utilization of the coverage plan in which they are enrolled.

Collaborate with Kansas Social and Rehabilitation Services to monitor progress toward enrolling all children in a child health insurance program.

c. Plan for the Coming Year

Enabling Services:

Healthy Start Home Visitors will continue to assist families to enroll in Medicaid/HealthWave programs. Outreach efforts will be launched for hard-to-reach special populations to improve their access to quality health insurance. Local coordination and collaboration between agencies will be improved to eliminate gaps and duplication.

Population-Based Services:

MCH staff will continue to support and promote outreach activities in local education agencies to enroll Medicaid eligible women and children and to encourage their use of health services available to them under each program and to educate families of children who receive either free or reduced school lunches of their eligibility for Medicaid/HealthWave.

MCH staff will continue to require Comprehensive School Health Initiative grantees to assist families to enroll and re-enroll their children in the Medicaid/HealthWave programs.

Infrastructure Building Services:

Kansas faces a steadily increasing undocumented population and must assist local health agencies to create a community plan for providing care for those uninsured children who remain ineligible for Medicaid/HealthWave programs.

MCH staff will continue the task force efforts to integrate and possibly merge the application for the free and reduced school lunch program with the Medicaid/HealthWave program for school-aged children. Continue to emphasize identification of a medical home for all children in Kansas. Health insurance coverage is a critical component for children in accessing a medical home.

MCH staff will continue to work with Child Care Licensing and Registration staff to incorporate enrollment of eligible children in Medicaid/HealthWave within the child care enrollment process. WIC programs will continue to provide Medicaid/HealthWave outreach materials to their respective clients.

Local health department staff will continue to receive technical assistance and training to help families enroll their children in the Medicaid/HealthWave programs and to counsel clients in the best utilization of the coverage plan in which they are enrolled.

MCH staff will continue to collaborate with Kansas Social and Rehabilitation Services in monitoring progress toward enrolling all eligible children in a health insurance program.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	90	90	90	97	97
Annual Indicator	94.3	92.1	94.2	96.5	
Numerator	147240	157307	170513	186041	
Denominator	156103	170712	181028	192743	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	99	99	99

Notes - 2002

2002 Data Source: Medicaid paid claims data file, Kansas Department of Social and Rehabilitation Services (numerator); estimate of actual Medicaid-enrolled population by increasing the actual Medicaid population by 4% and rounding to the nearest thousand. FY02 = Calendar year 2002.

Notes - 2003

2003 Data Source: Medicaid paid claims data file, Kansas Department of Social and Rehabilitation Services. # Medicaid enrollees (age1-21)who received a service during the reporting year (numerator); # Medicaid enrollees (denominator).

Notes - 2004

2004 Data Source: Currently, the data is not available. CY2004 data will be available after all the claims are paid (should be 98-99% complete by December 31, 2005).

a. Last Year's Accomplishments

In FY, 2003, the percent of potentially Medicaid-eligible children who received a service paid by the Medicaid Program was 96.5%. This rate is based on an estimated number of potentially Medicaid-eligible children and actual number receiving services.

Kansas Early and Periodic Screening Diagnostic and Treatment (EPSDT) services, Medicaid's comprehensive and preventive health program for eligible children under the age of 21, is commonly known as KAN Be Healthy (KBH) screen. In Kansas, in addition to the physician, physician assistant (P.A.) and Advanced Registered Nurse Practitioner (ARNP), registered nurses may complete the KAN Be Healthy Registered Nurse Training Program and provide the KBH screen to Medicaid-eligible children.

A report submitted by Kansas SRS to the Center for Medicare and Medicaid Services (CMS) showed the participation rate for Kansas Medicaid enrollees (ages 0-20) for KBH screens went from 64.4% in FFY 2003 to 87.8% in FFY 2004. This exceeded the CMS goal of 80% participation in EPSDT (KBH) screening services by April of 2005. During the Medicaid Management Information System (MMIS) data update in 2003, having a current EPSDT was removed as a requirement prior to receipt of expanded services. Now participants can receive services without having a current KBH on file. MCH staff serve on the advisory board and continue recommend the importance of keeping the KBH screening current according to the periodicity schedule.

Direct Health Care Services:

Although the goal was for the KBH to be provided within the medical home setting, in some communities, health departments continued to provide KBH services as the safety net when families struggle to navigate the managed care system.

Enabling Services:

At each home visit, Healthy Start Home Visitors reminded parents of the importance of affording their children access to the KBH screens their children were eligible to receive. Outreach to hard-to-reach populations has been enhanced by adding more language interpreters, access to sign language, and an expanded telephone interpreter service.

Population-Based Services:

Priority populations that received outreach and family support to access services for Medicaid children were families with children who receive either free or reduced school lunches, those who utilize health department programs (WIC, Immunizations, M&I) and Children with Special Health Care Needs.

Infrastructure Building Services:

MCH staff provided support and promotion of community collaborative partnerships that identify access gaps to service and explore how public and private resources can best be used to

provide improved access for Medicaid clients. MCH grantees received training to assist families with the universal HealthWave (Medicaid and SCHIP) application process and to facilitate access to direct services or provide the service to those unable to secure access within the current managed care delivery system.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Technical assistance and professional inservice training will be provided for physicians and their office nurses in fluoride varnish application				X
2. Support use of Medicaid/SCHIP services by enrolled students through Comprehensive School Health Centers.		X		X
3. Support use of Medicaid/SCHIP services for enrolled infants and children by the Healthy Start Home Visitors.		X	X	
4. Support use of services by Medicaid/SCHIP enrolled infants and children through MCH grants to local agencies.		X	X	X
5. Support use of services by Medicaid/SCHIP enrolled children in Services for Children with Special Health Care Needs		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Health Care Services:

Fewer health departments provide KBH screens; instead they facilitate children receiving services from their medical homes.

Health department staff applied preventative fluoride varnish and billing codes allowed for reimbursement. Increased numbers of Medicaid children were provided fluoride varnish applications.

Enabling Services:

At each home visit, HSHVs continue to provide outreach and family support so that families will follow through in securing and keeping appointments and navigating their medical home system for services for their children.

Health department nurses were trained to apply fluoride varnish.

Population-Based Services:

Comprehensive School Health Clinics and local/rural health departments continue to assist families with enrollment and referral services and to provide direct services or make a referral to receive services from designated medical home providers.

CSHCN was awarded an incentive award from Champions for Progress to convene a Statewide Stakeholder's meeting to assess the current needs and recommend solutions to improve access and services for this population. A strong emphasis has been to link children with a medical home from which to receive services.

Infrastructure Building Services:

MCH staff continue to provide support and promote community collaborative partnerships that identify access gaps to service and explore how public and private resources can best be used to provide and improve access for Medicaid clients.

MCH staff continue to train new local health department staff to assist families with the universal Medicaid/HealthWave application process and to facilitate access to the direct services or provide the service to those unable to secure access within the current managed care delivery system.

c. Plan for the Coming Year

Direct Health Care Services:

Medicaid children will continue to receive fluoride varnish applications through their health departments and their medical homes.

More Medicaid children will receive KBH assessments and preventive health services from their medical home providers and fewer direct services from local health departments. Local health departments will provide education, outreach and facilitation to families ito assist them in navigating the managed care system and to improve utilization of services through their designated medical homes.

Enabling Services:

HSHVs will continue to provide outreach and family support so that families will follow through in securing and keeping appointments and navigating their medical home systems for services for their children.

Technical assistance and professional inservice training will be provided for physicians and their office nurses in fluoride varnish application by State MCH staff and the Deputy Dental Director.

Population-Based Services:

Comprehensive School Health Clinics and local/rural health departments will continue to assist families with enrollment and referral services and will provide direct services or make a referral to receive services from designated medical home providers.

CSHCN Champions for Progress will continue to convene stakeholders to assess current needs and recommend solutions for improving access and services for this population. A strong emphasis is to link children with medical homes.

Infrastructure Building Services:

MCH staff will reach out to physician office staff with training opportunities in fluoride varnish application.

A basic mental health screening, the Pediatric Symptom Checklist will be incorporated into the KAN Be Healthy assessments on all Medicaid children receiving KBH services.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.2	1.2	1.2	1.0	1.0
Annual Indicator	1.4	1.3	1.3	1.1	
Numerator	548	496	515	447	
Denominator	39654	38832	39338	39353	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.9	0.9	0.8	0.8	0.8

Notes - 2002

2002 Data Source: Kansas Vital Statistics, 2001 resident data.

Notes - 2003

2003 Data Source: Kansas Vital Statistics, 2003 resident data.

Notes - 2004

2004 Data Source: Currently, the data is not available. Estimated release date is September of 2005.

a. Last Year's Accomplishments

In 2003, very low birth weight (VLBW) infants made up 1.1% of all live births in Kansas in comparison to 1.4% nationally. In Kansas, the percent of VLBW infants has decreased in the last 5 years (p = .01) approaching our target of 1.0%.

Direct Health Care Services:

In 2004, 89 local health departments, hospitals, regional county health agencies were provided funds to support prenatal care/care coordination of Maternal Child Health (MCH) services to 11,432 pregnant women and infants. Services were prioritized for populations at increased risk of delivering very low birthweight infants: adolescents, minority populations, low income families, substance users and those who have less than a high school education.

Enabling Services:

Healthy Start Home Visitors (HSHV) provided outreach, education, support and referrals to pregnant women. HSHV services stress proper nutrition, smoking cessation, early prenatal

care. Women are linked to health cae and social services.

Adolescent pregnancy risk reduction efforts and abstinence education programs that have the potential to decrease the number of adolescent pregnancies and subsequent delivery of very low birth weight infants continued.

The Perinatal Association of Kansas 2004 annual conference focused on mental health issues that have been shown to have a significant impact on pregnancy outcomes.

Infrastructure Building Services:

The Perinatal Association of Kansas (PAK) is a multidisciplinary group of professionals with particular perinatal health care expertise, ie. perinatology, neonatology, obstetrics, pediatrics, etc. KDHE maintains a contract with this organization to provide consultation and assistance to the KDHE regarding perinatal issues. A focal point has been fetal and infant mortality, reduction in low birthweight and very low birthweight live births.

KDHE staff monitored resident and hospital occurrence data relating to the very low birthweight live births. Perinatal outcome data (Perinatal Casualty Report) was provided to all in-patient obstetrical facilities to be used by them in evaluating appropriate management and timely referral and transport of high-risk maternal/fetal cases to specialty and subspecialty perinatal care providers/centers for delivery.

Collaborative efforts by KDHE/BCYF with federal Healthy Start projects/initiatives, community action groups, faith-based organizations and other State agencies continued.

A provider-driven perinatal referral system continued that assures access to city/county/regional consultation between primary obstetrical care providers and specialty maternal-fetal medicine professionals.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Education of providers about LBW risk factors and prevention				X
2. Healthy Start Home Visitors continue to link families to essential health care and social services		X		X
3. Partnership with OLRH to provide second annual Public Health Nurse Conference				X
4. Partnership with Perinatal Association of Kansas in planning conference with mental health focus				X
5. WIC-Medicaid-Vital Statistics to analyze birth records matching data to better identify high-risk pregnant women			X	X
6. Distribute Perinatal Casualty Report to all in-patient obstetrical facilities for management and referral of high-risk pregnancies				X
7. Education for Healthy Start Home Visitors on risk factors associated with LBW		X		X
8. Partner with Migrant Farm Worker Health Program and other Primary Care Projects to link high-risk women to services		X		X
9. Partner with March of Dimes in promoting prematurity campaign and				X

continue folic acid promotion				
10. Consult with KPC to determine existing program/system effectiveness in reducing numbers of LBW/VLBW infants.				X

b. Current Activities

Direct Health Care Services:

In 2005, 89 local health departments, hospitals, regional county health agencies are being funded to support prenatal care/care coordination of MCH services; 8 agencies also provide medical prenatal care.

Enabling Services:

Kansas Healthy Start Home Visitors continue to reach out to pregnant women and their families by informing, supporting and linking these families to essential health and social services.

Kansas' agriculture industry attracts migratory farm workers who do not have access to prenatal care and are unable to access programs with citizenship requirements. HSHVs received education on how to link more of their pregnant clients to services for those who qualify for early prenatal care in order to lessen the chances of giving birth to VLBW infants.

Infrastructure Building Services:

KDHE/BCYF continues to contract with PAK to support the KPC in determining the effectiveness of programs in reducing the numbers of VLBW infants through the study and evaluation of existing programs and services.

A Perinatal Periods of Risk (PPOR) project began in Wichita as endorsed by the KPC. This project is currently in the process of completing Phase I and initiating Phase II.

KDHE/BCYF continues a partnership with the March of Dimes by participating in a Prematurity Summit for Kansas as part of the larger national March of Dimes Prematurity Campaign. In this Summit, members discussed potential prevention strategies and pledged to continue and forge new partnerships with one another in the prevention of VLBW births.

The Perinatal Casualty Report (perinatal outcome data), the Adequacy of Prenatal Care Utilization Index and selected Kansas and U.S. perinatal outcome data reports continues to be distributed to inpatient obstetrical facilities to aid in internal review of care.

KDHE/BCYF continue collaboration with Medicaid in data sharing for the purpose of outreach and linking low-income pregnant women to services.

KDHE/BCYF provides ongoing education of providers of Maternal & Infant (M&I) services and continues to assess and further outline the establishment of smoking cessation programs for pregnant women through local health departments including the use of the Kansas Tobacco Quitline. In addition, KDHE/BCYF combined efforts with the Kansas Public Health Nurses in providing education on prevention strategies aimed at decreasing the number of low birth weight (LBW) infants. Of particular note, training in smoking cessation (the Five-A Quit Model techniques) counseling was offered to conference participants as well as other available smoking cessation resources for pregnant women.

c. Plan for the Coming Year

Direct Health Care Services:

In 2006, 89 local health departments, hospitals, regional county health agencies will be funded to support prenatal care/care coordination of MCH services; 8 agencies also provide medical prenatal care

Enabling Services:

Healthy Start Home Visitors will continue to reach out to pregnant women and their families by informing, supporting, and linking these families to essential health and social services.

HSHVs will receive educational presentations in the areas of accessing their local mental health resources (Community Mental Health Centers, private providers, etc.) and in the identification of families who are in need of mental health services. Also, an interactive video on second generational poverty with a discussion will be presented. The HSHV will be involved in a discussion of what effects mental health and poverty have on the occurrence of VLBW infant births as well as some preventive measures that communities can provide to counteract these effects.

Population-Based Services:

KDHE/BCYF will partner with First Guard Health Plan on a LBW Performance Improvement Project. The HSHV program will help pregnant HealthWave (SCHIP) women by providing enhanced face-to-face outreach and family support services to our pregnant adolescents to reduce pre-term deliveries.

Infrastructure Building Services:

KDHE/BCYF and KPC will continue ongoing collaborations on program effects and monitoring of the PPOR project in Wichita and the development of a similar project in Kansas City.

KDHE/BCYF will continue distribution of the Perinatal Casualty Report, the Adequacy of Prenatal Care Utilization Index, and selected Kansas and U.S. perinatal data reports to all inpatient obstetrical facilities.

Ongoing education of providers of M&I prenatal care/care coordination about VLBW risk factors and interventions will continue. KDHE/MCH staff will continue to provide an annual conference/educational forum. The Perinatal Association of Kansas conference this year will focus on hot topics in perinatal and neonatal care.

KDHE/BCYF will continue to partner with March of Dimes in their Prematurity Campaign by furthering conversations begun at the Kansas Prematurity Summit and in developing and/or enhancing partnerships with stakeholders that were present.

KDHE will continue collaboration with Medicaid in data sharing and will continue adolescent pregnancy risk reduction efforts including abstinence education programs that have the potential to decrease the number of adolescent pregnancies and subsequent delivery of VLBW infants.

KDHE/BCYF will continue the establishment of smoking cessation programs for pregnant women in local health departments. This will be in collaboration with the Kansas Tobacco Use Prevention Program.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10	10	9	6.5	6.5
Annual Indicator	10.5	13.3	8.7	6.8	
Numerator	22	28	18	14	
Denominator	210118	210118	206787	204865	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.3	6.3	6	6	5.8

Notes - 2002

2002 Data Source: Kansas Vital Statistics, 2001 calendar year data (numerator); U.S. Census 2000 data (denominator).

Notes - 2003

2003 Data Source: Kansas Vital Statistics, 2002 calendar year data (numerator); U.S. Census estimates Bridged-Race Vintage data set(denominator).

The 2000 through 2002 numerators and/or denominators were updated.
ICD-10 coding (1999-2002) X60-X84,Y870.The rates calculated for 2002, 2003 may be unreliable due to small sample size.

Notes - 2004

2004 Data Source: Currently, data is not available. Data will be available in September of 2005.

a. Last Year's Accomplishments

In Kansas 2003, the rate for completed suicide in teens ages 15-19 was 6.8/100,000 population (95% CI, 3.7-11.4). Even though the 2003 rate is 21.8% lower than 2002 (8.7/100,000) completed suicide is still the second leading cause of death for Kansas teens. In 2002, the suicide rate for this age group was 8.0% higher than the national rate of 8.0 per 100,000. Healthy People 2010 objectives relating to this NPM are:18-1 reduce the suicide rate to 6.0/100,000; and 18-2 reduce the rate of suicide attempts by adolescents in grades 9 through 12 to a 12 month average of 1 percent.

Direct Health Care Services:

The Comprehensive School Health Center projects provide family therapist counseling by a local church minister. The goals of the program are to help identify needs of students and families, provide support to students and families, define goals to enable student success in the classroom, monitor progress, and readily intervene as appropriate. Interventions utilized are individual sessions, small group sessions, teacher input and family involvement.

Enabling Services:

Referrals for mental health counseling are provided through the Comprehensive School Health Center projects.

Population-Based Services:

A presentation on suicide prevention measures was provided during the annual Kansas School Nurse Conference. The Signs of Suicide Prevention Program, a high school-based program was presented to school nurses. This program focused on bringing students in need of service to the school's attention by educating teens about the signs of suicide and outlining steps for dealing with this mental health emergency. Other information relayed to school nurses attending the conference included a session on Management of Depression and Bipolar Disorders: A Guide for School Nurses that included information on: how to identify signs and symptoms of depression and bipolar illness in children and adolescents; the treatment modalities available; interventions for students in crisis; suicide assessment and interventions; and, how to evaluate appropriate referrals.

Infrastructure Building Services:

The Suicide Prevention Statewide Steering Committee, through monthly meetings, made progress toward the completion of a statewide suicide prevention plan.
"Improving the Health of Adolescents & Young Adults: a Guide for States and Communities" was provided to grantees of KDHE working with adolescents. The web site to the guidebook was sent out in the adolescent newsletter to all school nurses and public health departments and Maternal and Child Health programs.

The Statewide Suicide Prevention Steering Committee conducted a poster contest with entries from students in middle and high schools throughout Kansas. The theme centered on the warning signs of suicide. The posters were displayed during Suicide Prevention Week at the State Capitol during the legislative session. A Governor's proclamation of Suicide Prevention Week was signed.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in Suicide Prevention State Steering Committee.				X
2. Provide suicide prevention education and assessment tool to Kansas school nurses.	X			X
3. Provide public education and youth education through the Suicide Prevention Poster contest.			X	
4. Referrals for mental health counseling through the Comprehensive School Health Initiative.		X		X
5. Continue to finalize Kansas' Statewide Suicide Prevention Plan through the Suicide Prevention statewide steering committee.				X
6. Provide family therapist counseling in one of the Comprehensive School Health Initiatives.	X			
7.				
8.				
9.				
10.				

b. Current Activities

Direct Health Care Services:

Using MCH grant funds, the Comprehensive School Health Center projects provide family therapist counseling and work with telemedicine from Kansas University Medical Center to provide individual counseling.

Wichita Public School system, in Sedgwick County, has developed a Yellow Ribbon Program within their middle and high school. They have completed 200 presentations in their schools on depression and what to do if someone is suicidal. After the presentation, the pre and post test findings demonstrate a 15 to 20% positive change in student response. Along with change in attitude and knowledge, in Sedgwick County the number of adolescents less then 19 years old shows a decrease from 7 completed suicides in 2001 to 3 in 2004.

Enabling Services:

Case management and care coordination of students referred for mental health counseling is provided through the Comprehensive School Health Center initiative. Suicide prevention hot lines are available in Kansas: The National Hopeline Network, 1800-SUICIDE, the National Suicide Prevention Lifeline 1800-273-TALK, and in Sedgwick county, a local Suicide prevention line 316-660-7500.

Population-Based Services:

A poster contest sponsored by the Kansas Suicide Prevention Steering Committee usually held in the spring was delayed until the fall of 2005 along with suicide education and will coincide with Suicide Prevention Week in September. The contest solicits entries from middle and high school students throughout Kansas and posters are displayed at the State Capitol during Suicide Prevention Week. This year's theme is communication between parents and teens.

Infrastructure Building Services:

Review and possible revision of the statewide suicide prevention plan through a strategic planning process continues. The Suicide Prevention Statewide Steering Committee must determine the feasibility of the current plan, determine how to implement across the state, and then finalize evaluation methods.

c. Plan for the Coming Year

Direct Health Care Services:

Kansas School Nurses will receive the Yellow Ribbon Suicide Prevention Program and assessment tool.

Enabling Services:

Comprehensive School Health Center projects will continue referrals for mental health counseling where possible.

Population-Based Services:

The Kansas Suicide Prevention Steering Committee will adapt the poster contest to include entries of essays from students in middle and high schools throughout Kansas. The posters and essays will be displayed at various professional conferences. A Governor's proclamation during Suicide prevention Week in September will be signed.

The Yellow Ribbon Suicide Prevention Program will be presented at the annual Kansas School Nurse Conference along with information on forming a mental health crisis team for each school district in Kansas.

Infrastructure Building Services:

Plans to finalize the statewide suicide prevention plan through the Suicide Prevention Statewide Steering committee will continue with the intent to begin depression and awareness education. An ad hoc committee will be formed to propose a plan and timetable of activities for implementation.

KDHE Adolescent Health staff incorporates the developmental asset building framework into programs and concepts at the state and local levels from the "Improving the health of Adolescents and Young Adults: A Guide for States and Communities."

Adolescent Health staff collaborates with Injury Prevention, KDHE, to obtain a Youth Suicide Prevention and Early Intervention Grant.

The only data available for attempted suicides is self-harm hospital data that is not reliable because it does not separate self-harm from suicide attempts. There are Youth Risk Behavior Survey data will be evaluated to establish a baseline high risk behavior.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	82	83	84	85	86
Annual Indicator	74.7	80.3	82.6	78.5	
Numerator	355	354	375	321	
Denominator	475	441	454	409	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84	84	85	85	86

Notes - 2002

2002 Data Source: Kansas Vital Statistics, 2001resident data.

Five Kansas facilities for high-risk deliveries and neonates are: Columbia Wesley Medical Center in Wichita; Via Christi-St. Francis in Wichita; Stormont-Vail Regional Medical Center in

Topeka; Columbia Overland Park Medical Center in Overland Park; and the University of Kansas Bell Memorial Hospital in Kansas City.

Notes - 2003

2003 Data Source: Kansas Vital Statistics, 2002 resident data.

Six level III hospitals are: Columbia Wesley Medical Center (Wichita), Via Christi-St. Francis,1998-2000 (Wichita), Via Christi-St. Joseph, 2001-2002 (Wichita), Stormont-Vail Regional Medical Center (Topeka), Columbia Overland Park Medical Center (Overland Park), and Kansas Bell Memorial Hospital (Kansas City).

Notes - 2004

2004 Data Source: Currently, the data are not available. Estimated release date is September of 2005.

a. Last Year's Accomplishments

In 2003 in Kansas, 78.5% of very low birth weight infants were born at facilities for high-risk deliveries and neonates. This represents a decrease of 5.0% from 2002 (82.6%) and is less than that for 2001 (80.3%). However, this percentage is well above the current five-year low recorded in 2000 (74.7%). Further, there is an even greater difference between the 2003 (78.5%) and the Healthy People 2010 objective of 90%. The delivery of very low birth weight infants at facilities for high-risk deliveries and neonates is of concern as these facilities are very successful in their delivery and aftercare. Therefore, very low birth weight infants cared for in facilities successful and skilled at caring for high-risk deliveries and neonates stand a much greater chance of survival than for those who are not delivered and cared for at these more specialized facilities.

Infrastructure Building Services:

The Perinatal Casualty Report (a set of perinatal outcome data), the Adequacy of Prenatal Care Utilization Index and selected Kansas and U.S. perinatal outcome data reports continued to be distributed by KDHE/BCYF to all inpatient obstetrical facilities for their use in evaluating appropriate management and referral of high-risk maternal/fetal cases to specialty and subspecialty perinatal care providers/centers. MCH staff at KDHE monitored residence and occurrence data relating to delivery site for very low birth weight infants.

Kansas has continued to have a working provider-driven perinatal referral system that facilitates access to inter-city/county/region consultation between primary obstetrical care providers and specialty maternal-fetal medicine professionals. This system includes five hospitals across the state that are self-designated subspecialty perinatal care centers providing out- and in-patient high risk obstetrical/fetal and neonatal services: Wesley Medical Center, Via Christi, and St. Francis Hospitals in Wichita; Stormont-Vail Health Care Center in Topeka; Overland Park Regional Medical Center in Overland Park; and the University of Kansas Bell Memorial Hospital in Kansas City. Three of the subspecialty perinatal centers continued to provide formalized perinatal transport systems to maximize the potential for the delivery of referred high-risk obstetrical cases to their hospitals.

Obstetrical care providers in the public and private sectors continued to utilize a variety of methods to identify women at risk for preterm deliveries or other complications potentially leading to the delivery of very low birth weight infants.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. Ongoing education activities in partnership with PAK, hospitals and other health care providers				X
2. Distribution of Perinatal Casualty Report to providers for evaluation of high-risk case management				X
3. Ongoing partnerships with PAK, KHA and KPC in assessing need for improved transfer systems and protocols				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

KDHE/BCYF continues to distribute annual Perinatal Casualty Report to all in-patient obstetrical facilities for evaluation of perinatal care and service delivery as well as monitoring for the number of very low birth weight infants who are delivered at facilities for delivery of high-risk deliveries and neonates.

KDHE/BCYF provides assessment of residence and occurrence data relating to delivery site for very low birth weight infants and presents it to KPC.

KDHE/BCYF in collaboration with PAK provides education to MCH grantees, private providers and hospitals on best practices in perinatal health. Also, KDHE/BCYF and PAK disseminate perinatal best practice information through various electronic media and at educational conferences to similar groups of providers of perinatal health care services.

No movement was made this year toward development of a formal system of assessing hospitals that are self-designated as basic, specialty or subspecialty providers of perinatal care for changes in level of services provided, availability of transfer criteria and the presence of protocols for obstetrical case management.

c. Plan for the Coming Year

Enabling Services:

The KHA in partnership with the Perinatal Association of Kansas (PAK) discuss development of an education plan to providers of perinatal care at the local, county, regional and state levels about the advantages of having available protocols for obstetrical case management and transfer criteria.

The KHA in collaboration with PAK make delivering hospitals aware of which facilities within their region or within their regions or within the state can accept high-risk delivery cases and the care of neonates. Further, the hospitals that can deliver high-risk pregnancy cases and care for neonates should also alert the KHA and PAK if they stop offering any or all of these services.

Infrastructure Building Services:

Encourage collaboration between KPC and Kansas Hospital Association (KHA) in assessing self-designated providers of basic, specialty or subspecialty perinatal care for changes in level of services provided, availability of transfer criteria and the presence of protocols for obstetrical case management.

Encourage collaboration between KPC and KHA in addressing the issue of relatively low percentages of very low birth infants being delivered at facilities for high-risk deliveries and neonates.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87	87	87	87	88
Annual Indicator	86.3	86.0	86.1	87.2	
Numerator	34216	33410	33874	34298	
Denominator	39654	38832	39338	39353	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88	89	89	89	90

Notes - 2002

2002 Data Source: Vital Statistics, 2001 resident live births.

Notes - 2003

2003 Data Source: Vital Statistics, 2001 resident live births.

Notes - 2004

2004 Data Source: Currently the data are not available. Estimated release of 2004 data is September of 2005.

a. Last Year's Accomplishments

In 2003, the percent of infants born to pregnant women receiving prenatal care in the first trimester in Kansas was 87.2%. This represents a 1.1% increase over 2002 (86.1%) and 2000 (86.3%). This is still below the Healthy People 2010 Objective of 90%.

Direct Health Care Services:

In 2004, 89 MCH contracts were granted to local health departments, hospitals, regional county health agencies and other child health care providers. Prenatal care/care coordination services were provided to 11,177 mothers and 3,335 infants. These agencies set out to address low birth weight incidence and to reduce the barriers too early and appropriate prenatal care. A small number of providers (8) continued to provide medical prenatal services, as their community needs dictated.

Enabling Services:

Disseminated federally prepared print materials (e.g., Healthy Start Initiative that publicizes a toll-free hotline and ultimately connects with the Kansas MADIN toll-free hotline). The toll-free Make a Difference Information Network (MADIN) line is available to provide pregnant women information on resources that will facilitate their access to and compliance with prenatal care.

Continued collaboration with Medicaid to further refine outreach and case management strategies to assure entry into and compliance with prenatal care for pregnant women receiving Medicaid.

Continued collaboration with Farm Worker Health Program in assuring access to prenatal care services for a mostly Hispanic and Low German migrant population.

Population-Based Services:

KDHE/BCYF staff continued to partner with March of Dimes (MOD) by disseminating information/providing education on perinatal healthcare topics with a focus on high-risk pregnancy factors. MOD continued to provide support to public media initiatives as well on perinatal healthcare topics

Infrastructure Building Services:

KDHE/BCYF staff provided the Adequacy of Prenatal Care Utilization Index, the Perinatal Casualty Report and selected statistics for the United States and Kansas to all in-patient obstetrical facilities. Staff monitored live birth and death certificates for information pertaining to prenatal care entry and compliance trends across race and maternal age categories.

MCH staff provided technical assistance to MCH funded M&I clinics in the development and continuation of translation services and print materials primarily in Spanish.

Efforts continued to identify Kansas women at risk for late entry and/or noncompliance with prenatal care in collaboration with WIC, M&I, HSHV and Family Planning services.

MCH staff continued collaboration with March of Dimes, Juvenile Justice Authority, Pregnancy Maintenance Initiative projects and Comprehensive School Health Centers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide prenatal care/care coordination services as a gap-filling service.	X			
2. MCH 2010 state priority of access to prenatal care		X		

3. Partner with MOD Prematurity Campaign		X		
4. Provide toll-free MADIN line.		X		
5. Encourage greater use of readily available data systems (e.g., KIC, Vital Stats, etc)				X
6. Promote early and comprehensive prenatal health care through all available means.				X
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services:

M&I care coordination and HSHV outreach aimed to increase the number of pregnant women accessing early and comprehensive prenatal care services and access to comprehensive health care before, during and after pregnancy was identified in Kansas' MCH 2010 Needs Assessment as a statewide priority.

Partnered with the Low Birth Weight (LBW) Performance Improvement Project (PIP) begun by First Guard Health Plans and KDHE/BCYF and the Healthy Start Home Visitor Program to help pregnant women on Medicaid get into prenatal care.

Infrastructure Building Services:

In a continuing collaboration between KDHE/BCYF, PAK, March of Dimes, KPC and Kansas Action for Children every effort has been made to share and publish data, promote initiatives and distribute print and multimedia resources related to the importance of pregnant women receiving early and comprehensive prenatal care.

KDHE/BCYF is partnering with the March of Dimes National Prematurity Campaign in distributing educational materials relating to the prevention of premature born infants and participating in a Kansas Prematurity Summit in November, 2004 to garner support for the prevention of premature births among various stakeholders in Kansas.

MCH funded M&I clinics were encouraged to utilize the KIC data system to identify potential community needs and to partner with the Office of Local and Rural Health's Public Health Nurses in identifying where local/regional Community Health Centers are located and develop comprehensive perinatal health care for pregnant women to help assure access to care for underserved populations.

c. Plan for the Coming Year

Enabling Services:

Continue collaboration with partners listed under current activities section to continue the effort of promoting early and comprehensive prenatal health care for all pregnant women.

Infrastructure Building Services:

Continue collaboration with the partners listed under current activities section and the entire array of local obstetrical and perinatal health care providers to continue maximizing resources to provide conferences, initiatives and support of programs designed to promote and assure

access to early and comprehensive prenatal care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of births to Hispanic women having received adequate prenatal care (APNCU).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	70	70	70	71	73
Annual Indicator	63.8	56.5	63.8	65.1	65.1
Numerator	2945	2672	3102	3425	3425
Denominator	4618	4731	4864	5258	5258
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	73	73	74	74	74

Notes - 2002

Kansas Vital Statistics. FY02 = Calendar year 2001 data. APNCU = Adequacy of Prenatal Care Utilization Index. Numerator and denominator represents percentage of population receiving 'Adequate' or 'Adequate Plus'.

Notes - 2003

Data Source: Center for Health & Environmental Vital Statistics, calendar year, resident data.

The number of live births for both numerator and denominator only included live births where the number of prenatal visits and the month care began were reported on the birth certificate

Notes - 2004

2004 data is not available currently. Kansas Vital Statistics estimates 2004 data will be available Sept. 2005. The estimate for 2004 is provisionally set at the 2003 level.

a. Last Year's Accomplishments

The percent of births to Hispanic women having received adequate prenatal care was 65.1% in 2003, which compares to 80.4% for all live births in the same year. We have not met our goal for 2003 (71%); however, there has been improvement since 1999.

Enabling Services:

Updated materials on the KDHE website to address the need for Spanish language materials and information to improve utilization of prenatal care.

Continued education and outreach efforts provided by Teen Pregnancy Projects and the Disparity projects in Wichita and SW Kansas to improve pregnancy outcomes for Hispanic women of reproductive age.

Improved utilization of prenatal care by Hispanic women in collaboration with the Migrant Farm Worker Program.

Infrastructure Building Services:

Provided the Perinatal Casualty Report and the APNCU index to all in-patient obstetrical providers to promote data based decision-making.

In collaboration with PAK developed strategies to improve access to prenatal care in SW Kansas.

Revised local agency monitoring tool to address capacity and access issues related to improving utilization of prenatal care by Hispanic women.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribution of perinatal casualty reports to obstetrical providers to promote data based decision-making.				X
2. Work with PAK to develop strategies to reduce prenatal care disparity for Hispanic women.				X
3. Collaboration with Migrant Farm Worker Program to increase access to perinatal care.		X		X
4. Targeted approach to prenatal issues through use of PPOR analyses.				X
5. Education about importance of early prenatal care through Disparity projects.		X		
6. Provide educational materials on KDHE website		X	X	
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services:

Ongoing update of materials on the KDHE website to address the need for Spanish language materials and information to improve utilization of prenatal care.

Ongoing support of education and outreach efforts provided by Teen Pregnancy Projects and Disparity projects in Wichita and SW Kansas to improve pregnancy outcomes for Hispanic women.

Improve access to prenatal care for Hispanic women of reproductive age through collaboration with the Migrant Farm Worker Program.

Infrastructure Building Services:

In collaboration with KPC, continue to conduct PPOR analyses for the State and for the metropolitan areas of Wichita and Kansas City to identify potential barriers to prenatal care to idencate potential interventions at the community level.

Continue to provide APNCU and Perinatal Casualty Report to all in-patient obstetrical providers to aid in their decision-making processes.

Continue the ongoing collaboration with PAK.

c. Plan for the Coming Year

Work on this SPM will be continued in the years 2006-2010 as new SPM #1 - Increase early and comprehensive health care before, during and after pregnancy and new SPM #2 - reduce premature births and low birthweight.

State Performance Measure 2: *Data capacity of the MCH program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	35	40	40	40
Annual Indicator	0.4	0.5	0.5	0.6	0.7
Numerator	30	38	38	36	42
Denominator	72	72	72	64	64
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.8	0.8	0.8	0.8	0.8

Notes - 2002

This state performance measure is directly related to the data, epidemilogy, and anlaysis resources priority need. This need was identified across all population groups and Joint State Needs Assessment programs (MCH, Primary Care, and HIV/AIDS). "To carry out the 10 essential public health services, MCH programs need access to relavant program and policy information. This reuires basic data capacity on the part of the Title V agency including the ability to monitor health status, to investigate health problems, and to evaluate programs and policies. One measures of this capacity is the availability tof and use by State MCH program of key pubic health data sets..." (Title V Grant Guidance)

Notes - 2003

This state performance measure is directly related to the data, epidemilogy, and anlaysis resources priority need. This need was identified across all population groups and Joint State Needs Assessment programs (MCH, Primary Care, and HIV/AIDS). "To carry out the 10 essential public health services, MCH programs need access to relavant program and policy information. This reuires basic data capacity on the part of the Title V agency including the ability to monitor health status, to investigate health problems, and to evaluate programs and policies. One measures of this capacity is the availability tof and use by State MCH program of key pubic health data sets..." (Title V Grant Guidance)

Notes - 2004

This state performance measure is directly related to the data, epidemilogy, and anlaysis resources priority need. This need was identified across all population groups and Joint State Needs Assessment programs (MCH, Primary Care, and HIV/AIDS). "To carry out the 10 essential public health services, MCH programs need access to relavant program and policy information. This reuires basic data capacity on the part of the Title V agency including the ability to monitor health status, to investigate health problems, and to evaluate programs and policies. One measures of this capacity is the availability tof and use by State MCH program of key pubic health data sets..." (Title V Grant Guidance)

a. Last Year's Accomplishments

Kansas scores from 2000 to 2004 have ranged from 30 to 42, with a perfect score of 64 (72 previously). Kansas is over halfway towards achieving it's target. This measure relates to State Priority #3: Increase data infrastructure, epidemiological capacity and products of analysis for improved state and community problem-solving.

Infrastructure Building Services:

MCH programs have vital statistics, hospital discharge, and other data resources available through the Center for Health and Environmental Statistics with personal identifiers removed. The hosptial discharge data from the Kansas Hospital Association represents approximately 97% of Kansas community hosptials and also have been working on developing capacity to link databases between programs (MCH, WIC, Part C, CSHCN).

For the first time, the Kansa State department of Education (the state agency responsible for the Youth Risk Behavior Survey -YRBS) has data representative of the health behaviors of all students in the State. Quality YRBS data are now available due to maximizing participation by local school districts and weighting data.

Two oral health screening projects were done: (1) For the school year 2003-2004, school nurses performed oral health screenings on 2,622 school children in grades three and six using of a non-invasive laser fluorescent dental device. Of the students who were evaluated by a dentist following the school nurse referral, 82% required dental care. The outcomes of this project included: (a) identification of students who were in need of dental care, (b) expantion and/or implementation of communication between the dental community and the school nurse, and (c) promotion of the importance of oral health. (2) A population-based open mouth survey of Kansas third grade children was completed and the report was published in February 2005. This provides baseline information on the oral health status of children in the state. The survey collected information on caries (tooth decay), the prevalence of dental sealants on permanent molar teeth, and the need for urgent dental treatment. Other important information also was collected, such as the ability of families to obtain dental care, their insurance status, and intervals between visits to dental care providers. This will help to guide development of MCH/CSHCN program interventions.

The five-year MCH Needs Assessment (NA) facilitated by EnVisage Consulting has been completed and the final report is posted on the KDHE website. MCH/CSHCN convened experts to participate in the NA, select nine MCH priorities and indicators to measure progress.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Infant Birth/Death Certificates Linkage				X
2. Medicaid Eligibility/Paid Claims Linkage				X
3. WIC Eligibility Linkage				X
4. Newborn Metabolic Screening Data Linkage				X
5. Hospital Discharge Data Linkage				X
6. Birth Defects Surveillance System				X
7. Survey of recent mothers (such as PRAMS)				X
8. Survey adolescent health and behaviors (YRBS)				X
9. Improve operational efficiency and program operation of the CSHCN data system				X
10. PPOR project				X

b. Current Activities

Infrastructure Building Services:

Completion of three projects:

(1) Childhood poisoning survey: Data collection of a call-back survey developed in collaboration with the Mid-America Poison Control Center (MAPCC) to obtain Kansas data on childhood poisoning related to grandparents' medicaitons has been completed and the data will be analyzed. The Kansas data from the analysis will be used to design educational strategies for preventing accidental poisonings.

(2) PPOR (Phase II): Phase I of the Perinatal Periods of Risk have been completed and presented to the Kansas Perinatal Council (KPC). The Perinatal Council decided to initiate Phase II with particular emphasize on the areas that have show the greatest opportunity gaps in the periods of risk when compared with the internal comparison group. PPOR (Phase II) analysis of state and regional data is continuing as a project in collaboration of KPC.

(3) MCH annual summary: A production of the MCH annual summary is in the progress, which is designed to describe the public heatlh importance of the priorities, update quantitative indicators, and determine how well the priorities have been implemented in state and local planning.

CSHCN has an electronic linkage with the Medicaid information systems at the Central and Field offices. It is anticipated that this capability will be available for other state level MCH programs needing client based data.

BCYF plans to explore the capability of data linkage with the new WIC data system, other BCYF programs, and the vital statistics data system.

c. Plan for the Coming Year

This measure will be continued as part of the State Systems Development Initiative.

State Performance Measure 3: *Percent of Children under age 4 in motor vehicle crashes using proper child safety equipment.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	71	72	73	73	74
Annual Indicator	75.1	71.8	71.7	78.1	78.1
Numerator	4198	3958	3856	3901	3901
Denominator	5593	5513	5375	4992	4992
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	79	79	80	80	81

Notes - 2002

Data Source: Kansas Accident Records System, Kansas Department of Transportation. FY 02 = calendar year 2001. Records with unknown age and unknown safety equipment type excluded. "C" child restraints only counted. Shoulder and/or lap belt recorded as not properly restrained

Notes - 2003

Numerator: Number of children age 0 to 3 involved in a Kansas motor vehicle crash wearing a properly functioning child safety seat.
Denominator: Number of children age 0 to 3 with known safety equipment status involved in a Kansas motor vehicle crash.

Data Source: Kansas Department of Transportation - Kansas Traffic Accident Facts (Occupants*Birth-3 Years Old in Accidents - Safety Belt Usage ** History). *Excluding occupants in vehicle body types: motocycles, mopeds, farm equipment, all-terrain-vehicle, buses, trains, other, and unknown. **Safety belt usage=Child safety seat used property.

Notes - 2004

2004 data is not available currently. The estimate for 2004 is provisionally set at the 2003 level.

a. Last Year's Accomplishments

Direct Health Care Services:

Over 4,727 Child Passenger Safety Seats have been distributed to families with 65 of these supplied through local public health departments.

Enabling Services:

In Kansas 568 Child Passenger Safety Seat (CPS) technicians, a 191 member increase, and

28 volunteer CPS technician instructors worked with local and state SAFE Kid Coalitions and other community organizations to promote occupant safety education. 74 counties established permanent child passenger safety fitting stations throughout the state.

Kansas SAFE Kids assisted General Motors with the BM Autoshow in Motion, with 36 volunteers working more than 480 hours installing seats for participating children.

Healthy Start Home Visitors provided injury prevention and education activities including motor vehicle injury prevention. 42 HSHV's were trained as CPS technicians across the state.

Population-Based Services:

The American Academy of Pediatrics "Car Safety Seats: A Guide for Families 2004" was recommended for all local public health departments to distribute to families in their counties. This guide was also recommended for distribution by Healthy Start Home Visitors to all families during home visits.

Infrastructure Building Services:

The Kansas trauma system requested changes in the current trauma system criteria to include all injured children admitted to a hospital, regardless of length of stay or transfer to a hospital, which depicts a more accurate picture of the number of children injured in Kansas and how those injuries were sustained.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation in Kansas SAFE Kids Coalition				X
2. Collaboration with Kansas Department of Transportation (KDOT) data collection to target injury prevention efforts to match community needs.				X
3. Participation on the Emergency Medical Services for Children Coalition.				X
4. Support Kansas trauma system's revision of criteria for reporting all children injured and admitted to a hospital.				X
5. Child Death Review Board analysis of deaths of children ages 0-4 years that are involved in motor vehicle crashes.				X
6. Train Kansas Healthy Start home visitors as passenger seat technicians in counties that have not identified personnel for this service, with distribution of car seats at a no-cost or low-cost rental rate.		X	X	X
7. Child passenger seat distribution.	X			
8.				
9.				
10.				

b. Current Activities

Direct Health Care Services:

5,000 Child Passenger Seats were distributed to families.

Enabling Services:

A decrease in the number of counties with CPS technicians was identified, from 101 Kansas counties last year to 86 counties this year. MCH collaborated with the Kansas Department of Transportation to facilitate training of the Kansas Healthy Start Home Visitors staff to ensure that all 105 Kansas counties have CPS technicians.

Infrastructure Building Services:

MCH participates on the newly formed Emergency Medical Services Coalition to coordinate pediatric injury treatment and prevention educational programs across the state targeting local community public health and school nurses.

MCH staff continues to share Kansas Department of Transportation observation survey information with local communities.

Monitor the use of child (age 0-4) safety seat data by the local health departments. Ensure the provision of education and service linkages targeting reduction of motor vehicle injuries through on-site visits and review of year end grant reporting documentation

c. Plan for the Coming Year

Work on this SPM will be continued in the years 2006-2010 as new SPM #6 - Reduce injury and death in children and adolescents.

State Performance Measure 4: *Number of Violent acts among 6th through 9th grade students per 100 enrolled students.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3.9	3.8	3.8	2.5	2.5
Annual Indicator	2.2	2.8	2.5	2.8	2.9
Numerator	3451	4302	3895	4362	4479
Denominator	155906	155930	155906	156069	155547
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.2	2.2	2.1	2.1	2.1

Notes - 2002

Data Source: Kansas Department of Education website. FY95=1994-1995 school year, FY96=1995-1996 school year, FY97=1996-1997 school year, FY98=1997-1998 school year,

FY99=1998-1999 school year, FY00=1999-2000 school year, FY01=2000-2001 school year, FY02=2001-2002 school year. Numerator: Number of (duplicated) violent acts against students and faculty in grades 6 through 9. Denominator: Number of students enrolled in grades 6 through 9.

Notes - 2003

Data Source: Kansas State Department of Education (KSDE) - www.ksde.state.ks.us/k12/state_bldg_reports.html, State Building Level Reports. All schools. FY99=1998-1999 school year, FY00=1999-2000 school year, FY01=2000-2001 school year, FY02=2001-2002 school year, FY03=2002-2003 school year.

Numerator: Number of (duplicated) violent acts against students and faculty in grades 6 through 9.
Denominator: Number of students enrolled in grades 6 through 9.

Notes - 2004

Numerator: Sum of "duplicated violent acts against students" and "duplicated violent acts against faculty" for grades 6 through 9. Violent acts are defined by KSDE "malicious acts against students/staff which results in the student receiving an out-of-school suspension or expulsion."
Denominator: Number of enrolled students in grades 6 through 9.

Data source: Kansas State Department of Education (KSDE) website. State Building-Level Reports.

a. Last Year's Accomplishments

Direct Health Care Services:

Two of the Comprehensive School Initiative Health projects provide counseling and referrals as needed to meet the needs of the adolescents and their families.

Infrastructure Building Services:

The monthly MCH newsletter (ZIPS) provided local health department nurses, social workers, Healthy Start Home Visitors, and school nurses information and resources (such as websites and curricula) to promote healthy relationships and avoid bullying and violence.

All public health staff who work with children and families were encouraged to attend the Governor's Conference for the Prevention of Child Abuse and Neglect. Workshop topics included: "Building Positive Relationships with Children" discussed strategies that help children develop through emotional literacy; "The Management of Anger in Adult-Child Relationships: The Fireworks Approach" presented a new extension program on anger management called Fireworks; "Picture This: Nurturing Positive Mental Health in Children" discussed the mportance of building and maintaining close social relationships with peers, family members, and other significant adults in a child's life; "Adults and Children (ACT) Together Against Violence" discussed the program that offers knowledge and skills to professionals who work with families and children in preventing the development of aggressive behaviors in young children;

"Using Conflict Resolution & Negotiation Skills in Child Welfare" focused on the skills social workers and other community workers can use in their everyday work with families; "Understanding Discipline: Encouraging Self-Discipline and Avoiding Self Destructive Behaviors and Potential Abuse" highlighted specific approaches to child discipline and the avoidance of self-destructive behaviors and avoidance of abusive potential; "Healthy Boundaries Equal Stress Management" informed professionals it is important to create a healthy boundary system and to teach and model boundaries to challenged families; "Multidisciplinary Response to Truancy of Children and Teens" discussed the cause of and

interventions used to address truancy issues and to educate participants on the risk factors, legal ramifications, and familial dynamics associated with school failure.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education to school nurses regarding student violence and healthy relationships.				X
2. Collaborate with the Kansas Department of Education on mental health/violence reduction initiatives.				X
3. Provide counseling and referrals to students and families through the Comprehensive School Health Initiative.	X	X	X	
4. Provide education/resource information (such as curricula and websites) on promoting healthy relationships to LHD's, social workers, HSHVs and school nurses.			X	X
5. Provide education for all LHD staff through the Governor's Conference for the Prevention of Child Abuse and Neglect.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Health Care Services:

Two of the Comprehensive School Health Initiative projects will continue to provide counseling and referrals as needed to meet the needs of the adolescents and their families.

Enabling Services:

Local health department staff including the Healthy Start Home Visitors receive training to identify violent relationships and how to initiate referrals.

Infrastructure Building Services:

To increase the knowledge of nurses working in a school setting, a presentation on violence was conducted at the Annual School Nurse Summer Conference. The first presentation entitled, "Bullies and Their Victims: Strategies to Help Both" discussed how adults can help kids learn to more effective in dealing with bullying by discussing what the behavior is and how to stop it.

Information was provided to the Healthy Start Home Visitors during their Regional Training on how to recognize violence and how to promote healthy relationships.

Upon release of the document, "Improving the Health of Adolescents and Young Adults: A Guide for States and Communities" technical assistance was provided to incorporate concepts into daily interaction in all systems of care with adolescents.

c. Plan for the Coming Year

Work on this SPM will be continued in the years 2006-2010 as new SPM #6 - Reduce injury and death.

State Performance Measure 5: *Percent of children who are overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	6.9	6.8	6.7	6	6
Annual Indicator	10.3	11.1	12.0	12.6	12.6
Numerator	3152	2577	2855	3412	3412
Denominator	30600	23218	23788	27076	27076
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	12	11.5	11.5	11

Notes - 2002

Data Source: CDC Pediatric Nutrition Surveillance System (PedsNSS), Kansas WIC Program. Represents percent of WIC children aged 24-59 months with high weight for height (greater than or equal to the 95th percentile). Recently, CDC revised its guidelines on how PedNSS data are evaluated. In so doing, CDC reevaluated national and state trends. Now, when multiple records are submitted for a child during the reporting period, CDC creates a unique child record that contains some data from all available records. These changes affected the overweight rates for 2001 and past years for both Kansas and the U.S.

Notes - 2003

Kansas WIC data of children, ages 2-<5, used as a proxy measure.

Data Source: Pediatric Nutrition Surveillance System (PedNSS), Kansas WIC Program - Table 2C from Summary of Health Indicators Children Aged <5 years. Recently, CDC revised its guidelines on how PedNSS data are evaluated. In so doing, CDC reevaluated national and state trends. Now, when multiple records are submitted for a child during the reporting period, CDC creates a unique child record that contains some data from all available records Therefore, 2001, 2002, and 2003 data are not comparable with previous years.

Notes - 2004

2004 data is not available currently. The estimate for 2004 is provisionally set at the 2003 level.

a. Last Year's Accomplishments

Enabling Services:

A grant was funded through the Sunflower Foundation to adapt the curriculum, Nutrition: Good For You previously developed for childcare providers. The physical activity lesson was broadened to include healthy eating messages for WIC families. The project includes evaluating four different strategies for delivering physical activity and health eating behavior messages in four counties.

Infrastructure Building:

A Sunflower grant was received by Washburn University, Division of Continuing Education. The grant expanded "KAN Be Healthy" statewide training to include an exercise and nutrition component plus training for EPSDT nurses to better evaluate BMI. WIC/MCH nutritionists were consulted on this project.

Within the new WIC automation system data on the hours of TV/Video viewing of children are collected.

The action plan developed by the Kansas USDA nutrition programs included staff representing School Lunch, School Breakfast, Nutrition Network, Expanded Food and Nutrition Education Program, CSFP and WIC. The goal is to AEducate individuals, families and communities about healthy dietary patterns and regular physical activity, based on the Dietary Guidelines for Americans@. The plan to implement a community wide event that coordinates activities for all the USDA nutrition programs was achieved in one community. This action plan was coordinated through the Kansas Nutrition Network with support from BCYF/Nutrition & WIC Services staff.

KDHE/ Bureau of Health Promotions was funded through the Sunflower Foundation to evaluate the height and weight of approximately 4,000 children (K through 12) in randomly selected schools. This is an age group where height and weight data is missing in Kansas. BCYF has been a consultant in the development of this grant. The age range for this state performance measure was selected due to lack of Kansas data in school age children. KDHE hopes to have additional data by fall 2005. Currently there is self-reported data on children grades 6 through 12 from questions added to the Youth Tobacco Survey.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the nutrition education and/or nutrition assistance programs of the KNN and the Early Childhood Action Team.		X	X	X
2. Support the Kansas Council on Physical Fitness annual Kansas Kids Fitness Day.			X	X
3. Support the Early Childhood Action Team's goals to stress the interrelatedness of physical activity and nutrition.			X	X
4. Support LHDs plans for decreasing childhood obesity and increasing physical activity through the WIC and MCH Programs.				X
5. Support the Success by Six Nutrition Task Force in their efforts to increase physical activity and healthy eating behaviors in preschool children.				X
6. Provide consultation for the Kansas Child Health Assessment and Monitoring Project.			X	
7.				

8.				
9.				
10.				

b. Current Activities

Enabling Services:

For MCH funding to LHD, 29 have chosen to target the "reduce overweight" priority. The focus of this priority targets activities to prevent and reduce overweight in the child and adolescent populations.

Infrastructure Building:

A survey of school nurses is being piloted to assess if school aged children are being weighed, measured and referred if appropriate.

A series of 12 lesson plans are being developed to promote healthy eating behaviors, physical activity, improve family interactions and literacy. Each lesson plan will highlight a specific Kansas attraction or area. The lesson will incorporate a children's book, information about the Kansas location and parent handouts focusing on parent/child interactions.

The action plan developed by the Kansas USDA nutrition programs was expanded to include three communities implementing a community wide event to increase healthy eating behaviors including increased consumption of fruits and vegetables and increased physical activity.

c. Plan for the Coming Year

Work on this SPM will be continued in the years 2006-2010 as new SPM #5 - Reduce overweight.

Enabling Services:

In 2006 Local WIC Agencies may choose as a focus for their Nutrition Services Action Plan either healthy eating behaviors or program enhancement. If they choose the healthy eating behaviors, the Local WIC Agencies are ask to pick the top item that will encourage families to adopt healthier nutrition and/or physical activity behaviors. An example could be to encourage family members to watch less TV/videos.

Infrastructure Building:

Within the new WIC automation system the data on hours of TV/Video viewing of children will be used for evaluation at both the state and local level.

State Performance Measure 6: *Percent of children with at least one dental screen in the past year.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**

Annual Performance Objective	35	36	37	40	42
Annual Indicator	35.1	33.5	37.5	39.9	47.2
Numerator	11297	11688	13526	14917	18650
Denominator	32198	34876	36099	37427	39480
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	50	52	52	54

Notes - 2002

Numerator: Number of KBH-eligible children ages 6 through 9 years with at least one KBH dental screen.
Denominator: Number of KBH-eligible children ages 6 through 9 years.

Data Source: Kansas Medicaid. FY = Calendar year data.

Notes - 2003

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) known in Kansas as Kan Be Healthy (KBH) data is used as a proxy measure of children ages 6 - 9 .

EPSDT is a required service under the Medicaid program for categorically needy individuals under age 21.

Numerator: Number of KBH-eligible children ages 6 through 9 years with at least one KBH dental screen.
Denominator: Number of KBH-eligible children ages 6 through 9 years.

Data source: Kansas Medicaid, KAN Be Healthy Annual Participation Report, Department of Social and Rehabilitation Services (SRS). FFY03=Calendar Year 2003.

Notes - 2004

Final Report, 5/05
EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) known in Kansas as Kan Be Healthy (KBH) data is used as a proxy measure of children ages 6 - 9 . EPSDT is a required service under the Medicaid program for categorically needy individuals under age 21.

Numerator: Number of KBH-eligible children ages 6 through 9 years with at least one KBH dental screen.
Denominator: Number of KBH-eligible children ages 6 through 9 years.

Data source: Kansas Medicaid, KAN Be Healthy Annual Participation Report, Department of Social and Rehabilitation Services (SRS). FFY04=Calendar Year 2004.

On October 1, 2003, SRS initiated a new Medicaid/SCHIP Management Information System. Conversion of data from the old system to the new system continued into 2004. This is likely responsible for any data irregularities. MCH will continue to monitor.

a. Last Year's Accomplishments

Direct Health Care Services:

CSHCN provided dental services for uninsured special health care needs children as part of an overall health plan.

Enabling Services:

CSHCN provided case management services for uninsured special health care needs children who need dental services as part of an overall health plan. Staff are coordinating with Medicaid in assuring that school nurses receive training appropriate for identification of oral health problems and referral to providers.

In 2004, the KDHE, Kansas school nurses, and public health department nurses began working together on an oral health screening project using DIAGNOdent to assess the oral health of Kansas children. A DIAGNOdent is a non-invasive laser dental device that screens for cavities and decay in children's teeth. The project entailed training nurses in using a DIAGNOdent to screen and assess the oral health of school-age children. The goals of the project were to promote prevention, early identification of dental problems, and aid in the collection of data to help determine the oral health status of the student population in Kansas. Training sessions were offered in six locations in the state. Participants learned the relationship between oral health and general health; that dental caries is an infectious and transmissible disease; how to develop strategies to encourage community partnerships to address dental care issues; and instruction on DIAGNOdent equipment. Twenty-five nurses received DIAGNOdent training the first year and subsequently screened 2,000 children. Children needing dental treatment were referred to local dentists and the nurses acted as case managers to ensure follow-up treatment was received. The project is helping to promote awareness and direct children in need of dental treatment to community providers.

Population-based Services:

Staff provided outreach/public education relating to oral health through school nurses, public health nurses, Healthy Start home visitors provided outreach and support to families in accessing KBH services.

Infrastructure Building Services:

KDHE and the Kansas Health Institute collaborated on an analysis of a baseline survey of over 1,000 children thate were screened and then studied oral health issues facing third graders across the state based on region, family income status, race and ethnicity, and county population density. The findings will help to guide development of MCH/CSHCN program interventions. Training in oral health issues was provided to school nurses at their annual conference. The KDHE/Oral Health Initiative website was initiated for school nurses. MCH staff continued to serve as a resource to the new Oral Health Kansas coalition. MCH coordinated with the Kansas Dental Association and Dental Hygienist Association to troubleshoot issues between Medicaid and dental Providers.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete an open mouth survey of 3rd grade children.				X
2. Develop an oral health website to educate professionals about normal and abnormal conditions/pathology of the mouth.			X	X

3. Education professionals about oral assessment/screening, anticipatory guidance and fluoride varnish application.				X
4. Education child care provider s about caries prevention and referrals to dental professionals.				X
5. Collaborate with other agencies and associations to introduce program strategies.				X
6. Serve in leadership role in developing an Oral Health Kansas coalition and OHK Board.				X
7.				
8.				
9.				
10.				

b. Current Activities

Direct Health Care Services:

CSHCN provides dental services for unisured special helath care needs children as part of an overall health plan.

Enabling Services:

CHSCN provides case management services for uninsured special health care needs children who need dental services as part of an overall health plan. Staff are coordinating with Medicaid in assuring that school nurses receive training appropriate for identification of oral health problems and referral to providers.

Population-Based Services:

Staff are providing outreach/public education relating to oral health through school nurses, public health nurses, Healthy Start home visitors who serve in an outreach role for local health departments.

Infrastructure Building Services:

Outsourcing to the Kansas Health Institute for analyses of results of our first open mouth survey of Kansas 3rd graders. The KHI completed the report which was printed and is being disseminated throughout the state. Trainign for school nurses in oral health issues continues. KDHE/Oral Health Initiative website is maintained. MCH serves in a lead role on the Oral Health Kansas coalition. The MCH oral health consultant works with the Kansas Dental Association and the Dental Hygienist Association to assure enrollment of dental professionals as Medicaid providers.

c. Plan for the Coming Year

Work on this SPM will be continued in the years 2006-2010 as a focus issue even though it was not selected as one of the nine priority needs in MCH 2010.

State Performance Measure 8: *Percent of infants who have received health care according to the recommended schedule.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	91	92	68	68
Annual Indicator	95.0	89.3	67.6	93.3	133.5
Numerator	31981	32646	32571	46882	71197
Denominator	33658	36542	48164	50271	53349
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96	96	98	98	98

Notes - 2002

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) known in Kansas as Kan Be Healthy (KBH) screening data was used as a proxy measure of percent of Kansas infants who receive health care according to the recommended schedule.

EPSDT is a required service under the Medicaid program for categorically needy individuals under age 21.

Numerator: Actual number of KBH screens (FFY).
Denominator: Expected number of KBH screens (FFY) for infants under age 1 based on periodicity schedule, enrollment period, and other factors.

Data source: Kansas Medicaid, KAN Be Healthy Annual Participation Report, The Kansas Department of Social and Rehabilitation Services (SRS)

Notes - 2003

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) known in Kansas as Kan Be Healthy (KBH) screening data was used as a proxy measure of percent of Kansas infants who receive health care according to the recommended schedule.

EPSDT is a required service under the Medicaid program for categorically needy individuals under age 21.

Numerator: Actual number of KBH screens (FFY).
Denominator: Expected number of KBH screens (FFY) for infants under age 1 based on periodicity schedule, enrollment period, and other factors.

Data source: Kansas Medicaid, KAN Be Healthy Annual Participation Report, Department of Social and Rehabilitation Services (SRS)

Notes - 2004

Final data - May, 2005
EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) known in Kansas as Kan Be

Healthy (KBH) screening data was used as a proxy measure of percent of Kansas infants who receive health care according to the recommended schedule.

EPSDT is a required service under the Medicaid program for categorically needy individuals under age 21.

Numerator: Actual number of KBH screens.
Denominator: Expected number of KBH screens for infants under age 1 based on periodicity schedule, enrollment period, and other factors.

Data source: Kansas Medicaid - KAN Be Healthy Annual Participation Report, The Kansas Department of Social and Rehabilitation Services

On October 1, 2003, SRS initiated a new Medicaid/SCHIP Management Information System. Conversion of data from the old system to the new system continued into 2004. This is likely responsible for any data irregularities. MCH will continue to monitor.

a. Last Year's Accomplishments

Enabling Services:

Healthy Start HomeVisitors (HSHV), advocates for families, informed them about the importance of enrolling children in Medicaid/HealthWave and receiving KAN-be-Healthy screenings according to recommended periodicity schedule.

Local health departments assisted families in assessment of income data, and referral for enrollment into the Medicaid/HealthWave program to support availability of KAN-be-Healthy screenings.

Infrastructure Building Services:

The local health department staff ensures that children who present for care are screened for eligibility and that families are assisted with application completion. Medicaid/HealthWave applications are initiated and submitted for all eligible children within the family. Case managers, public health nurses and outreach workers ensure that children are appropriately enrolled, and linked with a service provider. The local health department bills Medicaid for services provided to eligible children.

Local health department staff provided community outreach to all identified pregnant Medicaid women and other Medicaid-eligible pregnant women and informed them of available services. HSHV and M & I staff work with individual families to decrease the barriers in obtaining healthcare services (i.e., transportation, child care, lack of information about Medicaid/HealthWave.

KDHE/BCYF staff monitored the availability of KAN-be-Healthy (KBH) providers and provide opportunities for providers to receive in-service to update basic screening skills.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Referrals from local M&I, Healthy Start, WIC, CSHCN programs, screenings and other commuity partners for EPSDT and KBH.		X		
2. Collaborate with programs such as Infant/Toddler Services, and				

Parents as Teachers, child care providers to assess infants for eligibility and inform parents of importance of the regular KBH assessments for their infants.		X		X
3. Monitor the availability of KBH providers.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services:

Staff participate on the KBH Advisory Committee in order to advocate for quality standards, provider availability and service access for children/families.

Infrastructure Building Services:

Form interagency committee to meet and monitor participation in Medicaid/HealthWave and coordinate activities related to improving usage of services available for children.

Negotiate contracts with Medicaid managed care providers to add MCH contract agencies as preferred providers for care coordination to provide outreach and family support or in other ways partner to ensure that Medicaid clients make and keep appointments for KBH services.

Provide in-service trainings at HSHV regional meeting for local health department administrators, HSHV nurse managers, and HSHVs in billing and follow up for KBH screenings.

Collaborate with Kansas Child Care Regulation staff members to assess child health care access. Design standards to measure each child's health record for presence of medical home, health insurance status, and care received per EPSDT periodicity schedule. Children with identified needs are referred to local care coordinators for assistance in accessing health care.

Disseminate information about Kan Be Healthy screenings and periodicity schedules to daycare providers through their newsletters within other training opportunities.

Inform other community partners about eligibility guidelines and enrollment procedures for Medicaid through local contract agencies and encourage Kan Be Healthy screenings according to the recommended periodicity schedule.

c. Plan for the Coming Year

Even though this SPM was not continued as a State priority in the new state needs assessement, there will be continuing emphasis on linking families with health care services through Medicaid and SCHIP during 2006-2010.

E. OTHER PROGRAM ACTIVITIES

KWIC, the new web-based WIC data system, is fully implemented throughout the state. The data

system ensures more timely access to participation and budget information, risk data for evaluation purposes, and annual unduplicated counts. The system serves as a model in the country and the Kansas program is providing consultation to other states that are considering adapting the Kansas system.

The Kansas Information for Communities (KIC) system on the KDHE website allows data users to prepare their own queries for vital event data such as births and pregnancies http://kic.kdhe.state.ks.us/kic/. The system is updated each year. MCH staff train local staff in use of the system for community needs assessment in selecting local MCH priorities. KIC -- an MCHB SPRANS project.

Kansas Infant-Toddler Services at KDHE purchased three PhotoScreeners and conducted a pilot project to determine the effectiveness of the new technology in detecting vision problems not detected using traditional tools and methods outlined in the Kansas Vision Screening Guidelines. This research project was expanded to additional sites with funding from the Kansas Lions Club.

The Sunflower Foundation provided funding for a WIC project to address nutrition and physical activity in young children. The project evaluated four different strategies for delivering physical activity and healthy eating behavior messages to young children participating in WIC programs.

BCYF staff were participants in the internal review process for the revision of Vital Statistics Certificates (Birth, Death, Marriage and Divorce). In the spring of 2003 MCH participated in meetings regarding suggested changes and merging of current certificates with the US Standard Certificates. The new system was implemented in January of 2005 although various components of the new system are still undergoing development such as the export files to congenital anomalies and newborn hearing screening.

The focus of Kansas Robert Wood Johnson Turning Point project is development of capacity to address racial/ethnic disparities in health status. A key element in that effort is better understanding of health data related to minority health status and partnering with minority communities to improve the documentation of health and disease in those communities. One of the products of the project is the document, Racial and Ethnic Minority Health Disparities in Kansas. This was released at Spring 2005 Minority Health Conference in Lawrence, Kansas.

Kansas MCH participated in the Rhode Island Kids Count School Readiness Initiative. MCH participated on the five member state team. This group has evolved into the Early Learning Coordinating Council with oversight of the State Early Childhood Comprehensive Systems Plan. The composition of the group has evolved as well, with foundation and business support for early childhood efforts. BCYF staff participate in a number of early childhood/school readiness work groups.

CSHCN contracted with Envisage consulting to evaluate their current data system. The current system is inadequate given the needs of the program. Envisage provided the program with recommendations for a new data system which will be considered as part of the CSHCN strategic plan. Kansas is a recipient of the Champions for Progress Incentive Award. The award was used to convene a statewide stakeholder's meeting that focuses on CSHCN and their families. Regional meetings are planned for this summer.

KDHE staff is involved in discussions with SRS to ensure referral for evaluation to Part C Infant-Toddler Services of all children birth to three years of age who have been victims of a substantiated case of abuse or neglect. KDHE plans to work with SRS and Part C providers across the state to assure appropriate evaluation and intervention for children identified with social/emotional/mental health needs through this process. Five percent of all children enrolled in KDHE, Part C Infant-Toddler Services are in foster care.

KDHE participates with the Kansas Department of Social and Rehabilitation Services in planning an annual Kansas Fatherhood Summit to promote healthy father/male involvement in the lives of children

through collaborative efforts. We also serve with Kansas Citizens United for Rehabilitation of Errants (KS CURE) in planning mentoring programs for children of prison inmates to help maintain the family structure in this difficult circumstance.

The American Lung Association of Kansas continues to provide leadership through the Kansas Asthma Coalition (KAC) with focus on evidence-based diagnosis and treatment through provider and consumer education efforts. MCH staff continues to provide asthma education to school and public health department nurses and serve on the KAC providing training on "Indoor Air Quality Issues." This resulted in an American Lung Association "Lung Champion" award for efforts in providing indoor air quality and asthma management education.

MCH child and adolescent health staff hosted an Adolescent Vaccine Update Teleconference for Kansas School and Public Health Nurses. This teleconference was a collaborative effort by BCYF and the Kansas Immunization Program, and was funded by Aventis Pasteur Pharmaceuticals. BCYF staff received a National Customer Service Award in October, from Aventis Pasteur recognizing their efforts in protecting human life through immunization.

Kansas Home Visitation Training Task Force was formed in 2002 to address the need for consistent training for home visitation staff across multiple programs, including Head Start, Parents as Teachers, Healthy Start Home Visitors, Part C Infant Toddler Programs and others. The Nebraska Early Childhood Training Center curriculum was selected by the Task Force as the standardized curriculum for Kansas home visitors. Funding for this project was obtained from the Region VII ACF office and from the Kansas Head Start Collaboration Office.

F. TECHNICAL ASSISTANCE

FFY 05, Steps in Establishing a Birth Defects Information System

Senate Bill 418 passed in the 2004 Kansas legislative session. It creates, pending the availability of funding, a birth defects surveillance system. The statutory language is similar to that of model statutes for the State of Ohio. BCYF submitted an application to the CDC for funding of a birth defects surveillance system. The application was approved but not funded. Resources are not available to establish a surveillance system at this time. Some very limited components of a system are maintained within the BCYF.

Technical assistance was obtained from Judith Gallagher from Health Systems Research to develop a strategic plan in collaboration with members of the newly formed Child and Adolescent Health Council. The members adopted a plan for the coming year: review of screening statutes in the state and other screening issues such as tools in use by practitioners.

FFY 06, Review of Current Kansas Newborn Screening System and Recommendations for Expanded Newborn Screening.

The MCH/CSHCN staff developed and submitted a request for a team review, headed by Brad Therrell of the National Newborn Screening and Genetics Resource Center in Austin, Texas. This request is pending at the time of the application submission although an August, 2005 has been suggested. Members of the KPC, Child and Adolescent Health Council, and the Kansas Heartland Genetics Consortium will be invited to participate in this process as stakeholders.

V. BUDGET NARRATIVE

A. EXPENDITURES

EXPENDITURES FFY 04

Comparing FFY 03 and FFY 04 federal MCH expenditures, there were increases noted for Children & Families Section (379K to $392K - $13,000 for operating and equipment purchases), Oral Health (from no prior allocation to $60,000), MCH ATL expenditures ($1.5 M to $1.98 M) shift in payment schedule from state fiscal year to federal fiscal year, Comprehensive School Health (from $60K to $118K). From FFY 03 to FFY 04 expenditures decreased in the following areas, Vital Statistics ($73K to $63K), Office of Local and Rural Health (From $74K to $37K), Child Care Licensing (from $285K to $205K), nutrition consultation to MCH through WIC (from $47K to $38K), Bureau of Health Promotion for Injury prevention (from $52K to $0), Immunization Program (from $38K to $5K), Newborn Screening (from $88K to $76K), CSHCN (from $1.9M to $1.6M), Director of Health (from $31K to $11K), Indirects (from $406K to $220K). Expenditures were the same for both years for Disparity grants, child health assessment at school entry, and MCH administrative support.

Comparing FFY 03 with FFY 04 state match expenditures, there were decreases in match for Vital ($54K to $0), Local and Rural Health ($55K to $27K), Child Care Licensing ($213K to $153K), C&F Section ($39K to $26K), Immunizations (from $28K to $0), Teen Pregnancy Prevention ($594K to $275K), MCH grants (from $1,453 to $1,880). Pregnancy Maintenance Initiative expenditures increased (from $75K to $225K). Expenditures in all other areas remained about the same from year to year. Total SGF expenditures of $3,495,184 plus tobacco settlement funds expended (Healthy Start Home Visitor program) of $250,000 totals $3,745,184. This is slightly over the federally required match of $3,722,659.

In 04, local agencies reported local match expenditures of almost $5 million on the quarterly affidavit of expenditures. In previous years, local match has been computed using percent match required by KDHE. This year actual expenditures were provided from the Affidavits submitted by local agencies. Adding the local matching funds of $4,994,668 to the state match of $3,754,184, a total of $8,748,852 is matched to the MCH Block Grant.

The State of Kansas is within the required maintenance of effort requirement of $2,352,511.

Information about the Federal-State Title V Block Grant Partnership is provided on the attached spreadsheet.

B. BUDGET

BUDGET FFY 06

The full amount of the anticipated federal Title V award, $4,939,926 is budgeted for FFY 06. This is a decrease of $23,619 from that awarded and budgeted for 05, and a reduction of $187,825 from the previous year. Setting aside these two reductions in federal funding in 04 and 05, using a consumer price index calculator, the MCH Block Grant has lost over 20% of its value over the past ten years due to inflation alone.

For FY 05, federal MCH dollars have been budgeted in conformance with the 30-30 requirement for Title V of the Social Security Act. Administrative costs are in compliance with the 10% limit. Kansas maintenance of effort requirement for state dollars is $2,352,511 and the Kansas 06 budget is in compliance with this requirement. Kansas uses both state and local matching dollars to meet its federal 75% matching requirement for FY 06.

In previous years, all budget reductions were absorbed at the State level. Local agencies had been held harmless from budget reductions. In FY 06, after years of reductions, it is no longer possible to

continue to absorb all cuts at the State level. For FY 06, there have been two shifts in MCH funding: $50,000 for teen pregnancy prevention was withdrawn when one project went out of business and the funding was not reawarded. Funds to reimburse local agencies for child health assessments at school entry were withdrawn.

The MCH/CSHCN Directors provide input into the allocation and budgeting process for the MCH Block Grant, into the state budget, and the process of prioritizing programs for reduced resources and/or elimination through the state MCH needs assessment. Input is provided after completion of analyses to determine continued compliance with the requirements of the federal legislation governing Title V. At this time Kansas is in compliance with all requirements of the law.

The Kansas economy has been slow to rebound compared to the U.S. The State revenue projections through the date of this grant submission continue to be lower than anticipated. Court-ordered increases in school financing may result in changes in the state budget. KDHE continues rightsizing efforts in order to sustain essential services and focus efforts on priorities. The new Director of Health plans to implement additional planning activities to prioritize programs. The five-year State MCH Needs Assessment process is expected to be useful in these processes.

Through the legislative appropriations process, state dollars were reinstated for Pregnancy Maintenance Initiative for SFY 06 in the amount of $300,000. The agency lost $250,000 from Tobacco Settlement funds for the Pregnancy Smoking Cessation program. Part C Infant Toddler program funding has remained relatively level from SFY 03 to SFY 06 despite some small federal reductions.

While the state reductions continue, there is other cost shifting from time to time in order to meet immediate needs.

The budget for FY 06 includes CSHCN contracts as follows: Advanced Orthopedics - $10,800; UKSM, Wichita Medical Practice Assoc - $83,500; KUMC, Dept of Pediatrics - $125,362; Via Christi Regional Medical Center - $18,00; KUMC, Developmental Disabilities Center - $129,000; Cerebral Palsy Research Foundation, Wichita - $35,000; Salina-Saline Department of Community Health - $14,400; KUSM, Wichita - $245,373; KUMC, Developmental Disabilities Center - $146,000; Families Together - $45,000; Wesley Medical Center - $36,450; SIDS Network of Kansas $25,000. In addition, Wichita Medical Research and Educational Foundation is reimbursed $14 per sickle cell lab test. The Kansas State Department of Education and the Kansas Department of Social and Rehabilitation Services provide federal funding of $31,000 total to support the Make a Difference Information Network. The State Department of Education provides $7,000 for Special Child Clinics (rural outreach clinics (e.g., Oakley).

The Children & Families Section maintains contracts covering: perinatal and reproductive health services, and children and adolescent services. The contracts for this section include: comprehensive MCH services 87 contracts with local health departments and 4 other local agencies for coverage of all 105 counties; Family Planning 57 contracts with local health departments and 4 other local agencies for coverage of all counties; six contracts for the Section 510 Abstinence Education program; ten teen pregnancy prevention projects; two disparity projects for youth; and, 3-4 contracts for comprehensive school health clinics.

For more detail about the breakdown of the Federal State Title V Block Grant partnership, please see the attachment to this section.

A list of MCH contracts with local agencies for SFY 06 follows:

Barber Co Health Dept $4,725
Barton Co Health Dept (multi county) $65,569
Butler Co Health Dept $43,000
Chase Co Health Dept $2,551
Chautauqua Co Health Dept $7,610

Cherokee Co Health Dept $19,098
Cheyenne Co Health Dept $3,300
Clay Co Health Dept $41,133
Cloud Co Health Dept $9,790
Coffey Co Health Dept $2,000
Cowley Co Health Dept $21,898
Crawford Co Health Dept $44,714
Dickinson Co Health Dept $39,967
Doniphan Co Health Dept B $10,694
Douglas Co Health Dept $75,376
Edwards Co Health Dept $6,609
Ellsworth Co Health Dept $3,095
Finney Co Health Dept $139,395
Ford Co Health Dept $47,928
Franklin Co Health Dept $9,761
Geary Co Health Dept $105,100
Gove Co Health Dept B $3,115
Grant Co Health Dept $9,039
Gray Co Health Dept $5,000
Greeley Co Health Dept - $5,990
Greenwood Co Health Dept $8,000
Hamilton Co Health Dept $7,028
Harper Co Health Dept $5,220
Harvey Co Health Dept $47,958
Haskell Co Health Dept $7,821
Hodgeman Co Health Dept $3,600
Jefferson Co Health Dept $18,427
Johnson Co Health Dept $209,128
Kearny Co Health Dept $5,640
Kingman Co Health Dept $6,333
Kiowa Co Health Dept $5,677
Labette Co Health Dept $34,000
Lane Co Health Dept $5,342
Leavenworth Co Health Dept $76,000
Lincoln Co Health Dept $4,714
Logan Co Health Dept $4,720
Lyon Co Health Dept $79,461
Marion Co Health Dept $8,218
Marshall Co Health Dept B $13,713
McPherson Co Health Dept $27,874
Meade Co Health Dept $3,793
Miami Co Health Dept $11,827
Mitchell Co Health Dept $14,475
Montgomery Co Health Dept $44,422
Morris Co Health Dept $4,435
Morton Co Health Dept $3,501
NEK (multi county) $99,182
Nemaha Co Health Dept $12,907
Neosho Co Health Dept $20,260
Osage Co Health Dept $15,913
Ottawa Co Health Dept $9,500
Pawnee Co Health Dept $6,321
Phillips Co Health Dept $10,000
Pottawatomie Co Health Dept $32,016
Pratt Co Health Dept $9,000
Rawlins Co Health Dept $1,792

Reno Co Health Dept $112,650
Republic Co Health Dept $7,240
Rice Co Health Dept $8,860
Riley Co Health Dept $123,355
Rooks Co Health Dept $52,190
Rush Co Health Dept $4,607
Saline Co Health Dept $79,891
Scott Co Health Dept B $3,214
Sedgwick Co Health Dept $596,657
SEK (multi county) $56,984
Seward Co Health Dept $95,098
Shawnee Co Health Dept $486,666
Sheridan Co Health Dept $3,000
Stafford Co Health Dept $6,290
Stanton Co Health Dept $4,178
Stevens Co Health Dept $6,660
Sumner Co Health Dept $15,489
Thomas Co Health Dept $29,108
Wabaunsee Co Health Dept $7,000
Washington Co Health Dept $9,651
Wilson Co Health Dept $8,485
Wyandotte Co Health Dept $754,423
CHC of SE Kansas $58,421
Dodge City Family Planning Inc $23,201
Hays Area Children's Center $19,437
Mercy Hospital $67,707

Teen Pregnancy Prevention Contracts for SFY 06
City of Arkansas FACT Project $50,000
Wichita Family Services Institute $52,325
YWCA of Topeka $57,000
Crawford Co Health Dept $30,000
Four Co Mental Health Center $76,274
Hunter Health Clinic $73,034
Geary Co Health Dept $81,567
Douglas Co Health Dept $77,557
KUMC Project Hope $98,034
Wichita Family Services Institute 54,204
Disparity SW Kansas Ford Co Kids Count $94,558
Disparity Wichita Wichita Family Services Institute $74,557

Comprehensive School Health Centers Contracts for SFY 06
Atchison Co Health Dept $21,193
St. John Schools B $52,187
Other undetermined at this time -- $103,364

Pregnancy Maintenance Initiative contracts for SFY 05
annual competitive process (est. 4 projects)

SIDS Network of Kansas contract for SFY 06 $25,000

Women's Right to Know budget for SFY 06 $36,000

Detailed information about the Title V budget is provided in the attached spreadsheet.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting Documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.